BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
Carolyn Joan Rose, M.D.	)	Case No. 800-2016-019796
Physician's and Surgeon's Certificate No. A 41263	)	
Respondent	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on August 21, 2019.

IT IS SO ORDERED: July 22, 2019.

MEDICAL BOARD OF CALIFORNIA

Kristina D. Lawson, J.D., Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: CAROLYN JOAN ROSE, M.D. Mariposa, California Physician's and Surgeon's Certificate No. A 41263 Respondent.	Case No. 800-2016-019796 OAH No. 2018090744

PROPOSED DECISION

This matter was heard before Administrative Law Judge Erin R. Koch-Goodman, Office of Administrative Hearings (OAH), State of California, on April 24 and 25, 2019, in Fresno, California.

Sarah J. Jacobs, Deputy Attorney General, appeared on behalf of Kimberly Kirchmeyer (complainant), Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

John L. Fleer, Attorney at Law, appeared on behalf of Carolyn Rose, M.D. (respondent), who was present at hearing.

Evidence was received at hearing. The record remained open for the submission of simultaneous written closing briefs. On May 31, 2019, complainant's Closing Brief was received and marked as Exhibit 52; and Respondent's Closing Brief was received and marked as Exhibit I. The matter was submitted for decision on May 31, 2019.

FACTUAL FINDINGS

1. On October 9, 1984, the Board issued respondent Physician's and Surgeon's Certificate (license) No. A 41263. Respondent's license is in full force and effect until April 30, 2020, unless renewed or revoked. At all times relevant, respondent and her husband, Robert Rose, M.D., operated a private family practice in Mariposa City, a small rural community of approximately 2,000 people.

Complaint & Investigation

2. On or about January 2, 2016, following an arrest of respondent's patient for driving under the influence, the California Highway Patrol made a complaint to the Board, alleging respondent repeatedly overprescribed controlled substances to her patients. The Board opened an investigation and subpoenaed relevant medical and pharmacy records, procured Controlled Substances Utilization and Review System (CURES) reports, and interviewed respondent. In or about November 2017, Board Investigator Christopher George issued an Investigation Report. In March 2018, the Board retained Kristin Peña, M.D., family practice, to determine whether respondent practiced within the standard of care for a family practice doctor. In April 2019, Investigator George issued a Supplemental Investigation Report.

Accusation

3. On July 6, 2018, complainant, in her official capacity, made and served the Accusation[1] against respondent, alleging respondent committed gross negligence, repeated negligent acts, excessive prescribing of controlled substances[2], incompetence, and failed to maintain adequate and accurate medical records during her treatment of six patients (A – F). On July 12, 2018, respondent timely filed a Notice of Defense.

4. From 2015 to 2017, respondent was the primary care physician for Patients A – F.

a. Patient A had hypothyroidism, arthritis, melanoma, obesity, chronic sinusitis, oral herpes, insomnia, anxiety, depression, food allergies, emphysema, chronic back pain, degenerative disc disease and sciatica. Patient A saw respondent once a month. Respondent prescribed the following controlled substances to Patient A: Belsomra, Butrans, fentanyl, hydrocodone, methadone, Morphine, Norco (hydrocodone/acetaminophen), Nucynta, Opana ER, oxycodone, Percocet (oxycodone/acetaminophen), Soma, and temazepam. Patient A received a

[1] The Accusation is plead with great detail, including the entire CURES reports for each patient, and a date-specific accounting of visits, tests, and diagnoses for Patients A - F. However, at hearing, the parties argued the case in more general terms. Complainant's expert focused on her report findings, making reference to a few specific prescriptions and/or chart notes; and respondent testified, generally, about her practice and Patients A – F.

[2] Controlled Substances include: Schedule II drugs, including fentanyl, methadone, Morphine, MS Contin, Norco, Nucynta, Opana ER, and Oxycodone (Percocet); Schedule III drugs, including Butrans and hydrocodone; and Schedule VI drugs, including alprazolam (Xanax), Belsomra , Carisoprodol (Soma), clonazepam (Klonopin), diazepam (Valium), lorazepam (Ativan), temazepam (Versed/Restoril), and tramadol.

mammogram in July 2015. Thyroid testing was completed in March and May 2016. One urine test was completed in April 2016.

b. Patient B had chronic neck pain, of unknown etiology, migraines, insomnia, and anxiety. Patient B saw respondent every two months. Respondent prescribed the following controlled substances to Patient B: Klonopin, Norco, and Soma. Patient B had one urine test; one tetanus vaccination in April 2016; and signed a Controlled Substance Agreement, dated April 2017.

c. Patient C had chronic lumbar disc disease, chronic pain, muscle spasm, anxiety, insomnia, peptic ulcer disease, hypertension, gastroesophageal reflux disease, and fibrocystic breast disease. Patient C saw respondent every one to two months. Respondent prescribed the following controlled substances to Patient C: alprazolam, fentanyl, lorazepam, oxycodone-acetaminophen, and temazepam. Urine testing was completed in April and May 2015, and April 2016. Respondent received a letter from the insurance provider, expressing concern that respondent was prescribing high doses of opioids to Patient C; respondent did not respond.

d. Patient D had diabetes (well controlled), hypothyroidism, hyperlipidemia, emphysema, venous insufficiency, diabetic neuropathy, and schizophrenia, and was prescribed controlled substances by his psychiatrist. Respondent also prescribed tramadol, a controlled substance.

e. Patient E had neck and back pain, severe osteoporosis, anxiety, depression, hyponatremia, headaches, bleeding ulcers from NSAIDs, and vertebral fractures, and was prescribed controlled substances by his psychiatrist, including clonazepam. Patient E saw respondent once a month. Respondent prescribed the following controlled substances to Patient E: MS Contin, oxycodone, Soma, and tramadol. Urine testing was completed in April 2015, April 2016, February and March 2017.

f. Patient F had hyperlipidemia, tremor, hypertension, emphysema, gastroesophageal reflux, knee and spine arthritis, spinal stenosis, and medication allergies. Patient F saw respondent every three months. Respondent prescribed the following controlled substances to Patient F: diazepam, hydrocodone, Soma, temazepan, and tramadol.

Board Expert - Kristin S. Peña, M.D., Family Practice

5. Dr. Peña completed her Bachelor of Art in psychology in 1992 at the University of Colorado, Boulder, before earning her Medical Degree in 1997, from Michigan State University, College of Human Medicine, East Lansing and Kalamazoo. Dr. Peña then completed a three-year residency in family practice at Franklin Square Hospital in Baltimore,

Maryland, serving her last year as chief resident. In 2001, she became licensed to practice medicine in California. She is Board Certified by the American Board of Family Practice. Currently, Dr. Peña is a Faculty Physician, in the Family Medicine Residency Program, at the Community Memorial Hospital, in Ventura; and a Part-time Faculty Physician, at the Santa Barbara Neighborhood Clinics, in Isla Vista. She has worked in private practice, urgent care facilities, and hospital clinics. She has reviewed 20 to 25 cases for the Board since 2012.

6. The Board retained Dr. Peña to conduct a review of documents and provide an opinion as to whether respondent acted within the medical standard of care for a family practice doctor when she treated Patients A - F. The Board provided Dr. Peña with documents to review, including: medical records, prescriptions, pharmacy patient profiles, pain contracts, and toxicology results for Patients A - F; respondent's Board interview transcript; and the Board Investigative Report. On April 21, 2018, Dr. Peña issued a Report. Dr. Peña testified at hearing consistent with her Report.

7. Based upon her training and experience, and with direction from the 2007 and 2014 Board Guidelines on Prescribing Controlled Substances for Pain, Dr. Peña defined the standard of care to prescribe controlled substances for pain to require: a physical examination, including a review of systems, chronic illnesses, and a history of the presenting illness(es) for each patient visit; when prescribing controlled substances, consideration of safer alternative modalities; a risk/benefit discussion with the patient; verbal or written informed consent; review CURES reports; screen for opioid use/dependence disorder, and conduct urine screening for ongoing controlled substance prescriptions; monitor/treat chronic conditions; order/monitor preventative screening measures; and document all of the above in the patient chart. In sum, Dr. Peña found respondent deviated from the standard of care during her care and treatment of Patients A – F on 24 occasions, seven (7) extreme departures and 17 simple departures, and engaged in clearly excessive prescribing of drugs to Patients A, B, C, and E, as evidenced by CURES reports.

8. More specifically, Dr. Peña found respondent made the following extreme departures from the standard of care in her treatment of Patients A – F.

a. For Patient A, respondent prescribed Methodone without justification and failed to: provide informed consent, review CURES, perform routine toxicology, and screen for opiate dependence disorder.

b. For Patient B, respondent failed to: consider/document alternative modalities; and provide/document informed consent or proper warnings for the combination of prescriptions for opiates, Soma, and benzodiazepines in a patient with known alcohol use and mental health issues.

c. For Patient C, respondent failed to consider/document alternative modalities, and review CURES, or address aberrant toxicology results; and prescribed Ketorolac in a patient with known bleeding ulcers and failed to monitor renal function.

d. For Patient D, no extreme departures were found.

e. For Patient E, respondent prescribed Ketorolac in a patient with known bleeding ulcers.

f. For Patient F, respondent failed to confirm diagnosis and consider alternative modalities; and prescribed opioids without justification.

9. In addition, Dr. Peña found respondent made the following simple departures from the standard of care in her treatment of Patients A – F.

a. For Patient A, respondent failed to: adequately chart/document visit; provide informed consent or proper warnings for the prescription of high-dose opiates together with benzodiazepines; monitor and treat hypothyroid condition; and provide minimal preventative screening measures.

b. For Patient B, respondent failed to: adequately chart/document visit; confirm diagnosis; consider/document alternative modalities; conduct/document a risk/benefit discussion with the patient for the prescription of benzodiazepines, alcohol, and opioids; review CURES; and provide minimal preventative screening measures, including Tdap inoculation.

c. For Patient C, respondent failed to: provide/document informed consent or proper warnings for the prescription of multiple benzodiazepines in an elderly woman; review CURES; and screen for opioid dependence disorder.

d. For Patient D, respondent failed to: adequately chart/document visit; confirm diagnosis; consider/document alternative modalities; and provide/document informed consent or proper warnings for Tramadol.

e. For Patient E, respondent failed to: consider/document alternative modalities; provide/document informed consent or proper warnings for prescribing Soma in combination with benzodiazepines and opioids and monitor liver function (partially because she was unaware of Soma's addictive qualities); review CURES; and provide minimal preventative screening measures.

f. For Patient F, respondent failed to review CURES; perform routine toxicology; and screen for opiate dependence disorder.

10. Finally, respondent failed to document current medications for Patients A – F, as well as her rationale and/or justifications for prescribing such drugs to Patients A – F. Without more, the CURES reports are the only evidence of respondent's prescribing of

controlled substances to Patients A – F. Dr. Peña reviewed the CURES reports for Patients A – F, and found respondent prescribed clearly excessive drugs to Patients A, B, C, and E.

Board Guidelines For Prescribing Controlled Substances for Pain

11. In 1994, the Board adopted a policy statement entitled, "Prescribing Controlled Substances for Pain." The statement outlined the Board's approach to improving appropriate prescribing for effective pain management, while preventing drug diversion and abuse. The policy statement was the product of a year of research, hearings and discussions.

12. In 2002, as a result of Assembly Bill (AB) 487, a task force was established to review the 1994 policy statement and to assist the Division of Medical Quality to "develop standards to assure the competent review in cases concerning the management, including, but not limited to, the under treatment, under medication, and over medication of a patient's pain." The task force developed Guidelines for prescribing controlled substances to all patients with pain. In 2003, the Board adopted the Guidelines.

13. The 2003 Guidelines outlined six categories for consideration:

a. History/Physical Examination – "a medical history and physical examination must be accomplished";

b. Treatment Plan and Objectives – "the treatment plan should state objectives by which the treatment can be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if further diagnostic evaluations or other treatments are planned";

c. Informed Consent – "The physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian";

d. Periodic Review – "The physician and surgeon should periodically review the course of pain treatment of the patient and any new information about the etiology of the pain or the patient's state of health";

e. Consultation – "The physician and surgeon should consider referring the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives";

f. Records – "The physician and surgeon should keep accurate and complete records according to items above, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic review of the treatment plan."

14. The Guidelines mandate a medical history and physical examination and require the doctor "to discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian." While not required, the Guidelines suggest "[a] written consent or pain agreement for chronic use . . . [to] make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent." Finally, under Records, the Guidelines suggests that "[t]he physician and surgeon should keep accurate and complete records, . . . including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan."

15. The Board reissued the Guidelines in 2007, adopting the same six categories for consideration, and noting a change in law allowing the prescribing of opioids to addicts for care and treatment of a medical condition other than detoxification. The Guidelines acknowledge:

> Inappropriate prescribing of controlled substances, including opioids, can lead to drug abuse or diversion and can also lead to ineffective management of pain, unnecessary suffering of patients, and increased health costs. The Medical Board recognized that some physicians do not treat pain appropriately due to a lack of knowledge or concern about pain, and others may fail to treat pain properly due to fear of discipline by the board. These Guidelines are intended to improve effective pain management in California, by avoiding under treatment, over treatment, or other inappropriate treatment of a patient's pain and by clarifying the principles of professional practice that are endorsed by the Medical Board so that physicians have a higher level of comfort in using controlled substances, including opioids, in the treatment of pain. These Guidelines are intended to promote improved pain management for all forms of pain and for all patients in pain.

16. In 2014, the Board expanded the Guidelines, noting:

> These guidelines are intended to help physicians improve outcomes of patient care and to prevent overdose deaths due to opioid use. They particularly address the use of opioids in the long-term treatment of chronic pain. Opioid analgesics are widely accepted as appropriate and effective for alleviating moderate-to-severe acute pain, pain associated with cancer, and persistent end-of-life pain. [¶] . . . [¶] These guidelines underscore the extraordinary complexity in treating pain and how long-term opioid therapy should only be conducted in practice settings where careful evaluation, regular follow-up,

> and close supervision are ensured. Since opioids are only one of many options to mitigate pain, and because prescribing opioids carries a substantial level of risk, these guidelines offer several non-opioid treatment alternatives. These guidelines are not intended to mandate the standard of care. The Board recognizes that deviations from these guidelines will occur and may be appropriate depending upon the unique needs of the individual patients. Medicine is practiced one patient at a time and each patient has individual needs and vulnerabilities. Physicians are encouraged to document their rationale for each prescribing decision. Physicians should understand that if one is ever the subject of a quality of care complaint, peer expert review will be sought by the Board. The expert reviewer must consider the totality of circumstances surrounding the physician's prescribing practice (e.g., issues relating to access of care, paucity of referral sources, etc.) Specifically, experts are instructed to "define the standard of care in terms of the level of skill, knowledge, and care in diagnosis and treatment ordinarily possessed and exercised by other reasonably careful and prudent physicians in the same or similar circumstances at the time in question."

17. In 2014, the Guidelines expanded the categories for consideration to include: Patient Evaluation and Risk Stratification, Consultation, Treatment Plan and Objectives, Patient Consent, Pain Management Agreement, Counseling Patients on Overdose Risks and Response, Initiating Opioid Trial, Ongoing Patient Assessment, Compliance Monitoring, Discontinuing Opioid Therapy, and Medical Records.

Respondent

18. Respondent earned a bachelor's degree from the California State University, Los Angeles, before completing her Medical Degree at the Universidad Autónoma de Ciudad Juarez (UACJ) in 1980. Respondent then completed a six-month internship in internal medicine, followed by a three-year internship in family medicine at Wilmington Hospital in Delaware. In 1984, respondent became licensed to practice medicine in California. She was Board Certified by the American Board of Family Medicine from 1984 to 2010.

19. In 1984, respondent and her husband, Robert Rose, M.D., opened a practice together in Mariposa, a rural community with few doctors. The Mariposa County population is approximately 17,000, and the Mariposa City population is approximately 2,000. There are no local medical specialists.

20. Respondent practiced medicine for 30 years in Mariposa, without incident. She identified Patients A – F as longtime patients. She acknowledged prescribing controlled substances to all six patients; noting a few were already taking opioids when they came to her,

and she simply maintained their prescriptions and doses. When she prescribed a controlled substance, respondent would always discuss the risks/benefits with her patients. However, she admits to never documenting her risk/benefit or informed consent discussions in the chart; in school, she was taught to make chart notes brief. She did order preventative tests and make referrals, but not all patients were compliant, and she admits not following-up. For patient C, respondent acknowledged receiving a letter from the insurance provider, expressing concern that respondent was prescribing high doses of opioids to Patient C. Respondent did not respond, because she did not understand the importance of the information.

21. Respondent understands that medicine has changed, and she has done her best to keep up with current practices. At all times relevant, she admitted being unaware of the 2007 and 2014 Guidelines for the prescribing of controlled substances for pain. She prefers to use reference books for diagnostic and treatment assistance, including Principles of Ambulatory Medicine (1982) and Harrison's Principles of Internal Medicine (2005). In fact, she kept paper patient files until 2014, and only changed to electronic charts when she sold her practice, at the request of the new owners. She has had difficulty transitioning to using a computer, and did not actively begin consulting CURES reports until 2017 or 2018.

22. In 2014, Drs. Rose sold their Mariposa practice. They tried to transfer their patient population to the new owners, but many patients were unwilling to go. In 2016, Drs. Rose formally closed their Mariposa practice. In 2015, respondent began working for John C. Fremont Physicians, serving approximately 50 to 60 patients each week – geriatric, pediatric, and obstetrics and gynecology. In December 2018, respondent retired. In retirement, respondent would like to volunteer once or twice a month at the free medical clinics in Modesto. She does not want to practice pain management and is willing to permanently surrender her DEA certificate.

Discussion

23. The practice of medicine is constantly evolving, with advances in technology to diagnose, new drugs to treat, and enhanced practices to care for patients. Doctors must constantly learn, embrace, and adhere to new standards of care. Relevant here, the changing use of controlled substances to treat/manage pain. In 1990, the Intractable Pain Treatment Act established laws to assist physicians in the course of treatment for a person diagnosed with intractable pain. In 1994, the Board issued a policy statement on Prescribing Controlled Substances for Intractable Pain, to improve appropriate prescribing for effective pain management, while preventing drug diversion and abuse. In 2003, the Board adopted Guidelines for Prescribing Controlled Substances for Pain, intending to improve effective pain management; by avoiding under treatment, over treatment, or other inappropriate treatment of a patient's pain; and by clarifying the principles of professional practice that are endorsed by the Board so that physicians have a higher level of comfort in using controlled substances, including opioids, in the treatment of pain. The Guidelines were reissued in 2007, noting a change in law allowing the prescribing of opioids to addicts for care and treatment of a medical condition other than detoxification. In 2014, the Board adopted revised Guidelines, adding reference material on types of pain and special patient

populations, providing sample evaluation tools, and refining the categories of consideration for prescribing controlled substances for pain management.

24. As early as 2003, the Guidelines listed six categories for consideration: History/Physical Examination; Treatment Plan and Objectives; Informed Consent; Periodic Review; Consultation; and Records. Notwithstanding the Board's Guidelines, the "opioid epidemic" has been national news for more than 10 years. Doctors are the access point to opioids and they must remain steadfast in the screening/monitoring of patients for treatment of pain and opioid abuse.

25. At issue: respondent's care and treatment of Patients A – F from 2015 through 2017. In 2015, respondent admitted she: was unfamiliar with the Board's Guidelines on prescribing opioids; did not check CURES; wrote brief chart notes, failing to list medical history and physical examination for each appointment, and document her controlled substances risk/benefit discussions with patients and informed consent; received an insurance letter regarding Patients C, noting she was prescribing him high doses of opioids, but she did nothing; and was unaware Soma had addictive qualities when she prescribed the medication to Patient E. Respondent noted the considerable changes in medicine since she graduated in 1980; for example, she was taught to write brief chart notes, but now exhaustive and detailed chart notes required. In addition, she has found the transition to the computer to be difficult; hence, her limited use of CURES. Moreover, she prefers medical reference books to online sources for help with patient care and treatment, highlighting Principles of Ambulatory Medicine (1982) and Harrison's Principles of Internal Medicine (2005).

26. Respondent has dedicated her life to helping people. She practiced medicine in a small, rural community for more than 30 years. Her dedication is admirable. Nonetheless, respondent is required to keep abreast of medical issues effecting her practice and is responsible for practicing within the standard of care, at all times, regardless of geographic location. The risks of prescribing controlled substances has been a national issue for more than 10 years, and a Board issue for more than 20 years. In this case, respondent fell below the standard of care when prescribing controlled substances to Patients A – F. Her charting was scant, at best, providing little to no information about medical history, physical examination, informed consent, rationale for treatment, alternative modalities, etc. At the same time, the CURES reports show respondent prescribing a litany of controlled substances to Patients A – F. Notwithstanding the above, respondent's testimony evidenced her a lack of knowledge and awareness of the evolving standard of care for prescribing controlled substances. However, with education and monitored practice, respondent can provide medical care to patients without harm to the public practice.

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LEGAL CONCLUSIONS

Standard of Proof

1. To revoke or suspend respondent's medical license, complainant must establish the allegations and violations alleged in the Accusation by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The requirement to produce clear and convincing evidence is a heavy burden, far in excess of the preponderance of evidence standard that is sufficient in most civil litigation. Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

Applicable Laws

2. Business and Professions Code section 2234 requires the Board to "take action against any licensee who is charged with unprofessional conduct." "Unprofessional conduct includes, but is not limited to: (b) gross negligence, (c) repeated negligent acts, [and] (d) incompetence." "To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts." (Bus. & Prof. Code, § 2234, subd. (c).) Unprofessional conduct includes "repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees." (Bus. & Prof. Code, § 725, subd. (a).)

3. In addition, Business and Professions Code section 2266 states: "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

Cause for Discipline

4. Cause exists for disciplinary action under Business and Professions Code section 2234, subdivision (b), by reason of the matters set forth in the Factual Findings as a whole. Complainant proved, by clear and convincing evidence, respondent engaged in gross negligence in her care and treatment of Patients A, B, C, E and F.

5. Cause exists for disciplinary action under Business and Professions Code section 2234, subdivision (c), by reason of the matters set forth in the Factual Findings as a whole. Complainant proved, by clear and convincing evidence, respondent engaged in repeatedly negligent acts in her care and treatment of Patients A - F.

6. Cause exists for disciplinary action under Business and Professions Code section 2234, subdivision (d), by reason of the matters set forth in the Factual Findings as a whole. Complainant proved, by clear and convincing evidence, respondent engaged in incompetence in her care and treatment of Patients A - E

7. Cause exists for disciplinary action under Business and Professions Code section 725, subdivision (a), by reason of the matters set forth in the Factual Findings as a whole. Complainant proved, by clear and convincing evidence, respondent engaged in excessive prescribing in her care and treatment of Patients A, B, C, and E.[3]

8. Cause exists for disciplinary action under Business and Professions Code section 2266, by reason of the matters set forth in the Factual Findings as a whole. Complainant proved, by clear and convincing evidence, respondent failed to maintain adequate and accurate records for the prescribing of controlled substances to Patients A, B and D.

9. Considering the Factual Findings and Legal Conclusions as a whole, respondent's actions constitute cause for discipline. However, with monitoring and guidance, respondent can provide medical care to patients without harm to the public.

ORDER

Physician's and Surgeon's Certificate No. A 41263 issued to respondent Carolyn Joan Rose, M.D. is REVOKED. However, the revocation is STAYED, and respondent is placed on probation for three years upon the following terms and conditions:

1. **Education Courses**

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

[3] In Complainant's Closing Brief, she withdrew the allegations of excessive prescribing as to Patients D and F.

2. **Prescribing Practices Course**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but before the effective date of the Decision may, in the sole discretion of the Medical Board or its designee, be accepted towards the fulfillment of this condition if the prescribing practices course would have been approved by the Board or its designee if the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course or not later than 15 calendar days after the effective of the Decision, whichever is later.

3. **Medical Record-Keeping Course**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical recordkeeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical recordkeeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but before the effective date of the Decision may, in the sole discretion of the Medical Board or its designee, be accepted towards the fulfillment of this condition if the prescribing practices course would have been approved by the Board or its designee if the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course or not later than 15 calendar days after the effective of the Decision, whichever is later.

4. **Professionalism Program (Ethics Course)**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in professionalism program, that meets the requirements of Title 16, California Code of Regulations, section 1358.1. Respondent shall participate in and successfully complete the program. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment and the longitudinal component of the program not later than the time specified by the program, but not later than one (1) year following the classroom component. The program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but before the effective date of the Decision may, in the sole discretion of the Medical Board or its designee, be accepted towards the fulfillment of this condition if the professionalism program would have been approved by the Board or its designee if the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course or not later than 15 calendar days after the effective of the Decision, whichever is later.

5. **Practice Monitoring**

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

6. **Solo Practice Prohibition**

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease

the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, respondent's practice setting changes and respondent is no longer practicing in a setting in compliance with this Decision, respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

7. **Notification**

Within seven (7) days of the effective date of this Decision, respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

8. **Supervision of Physician Assistants and Advanced Practice Nurses**

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

9. **Obey All Laws**

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

10. **Quarterly Declarations**

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

11. **Compliance with Probation Unit**

Respondent shall comply with the Board's probation unit.

12. **Address Changes**

Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

13. **Place of Practice**

Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

14. **License Renewal**

Respondent shall maintain a current and renewed California physician's and surgeon's license.

15. **Travel or Residence Outside California**

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

16. **Interview with the Board or its Designee**

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

17. **Non-practice While on Probation**

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections

2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

18. **Completion of Probation**

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

19. **Violation of Probation**

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

20. **License Surrender**

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his or her license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

21. **Probation Monitoring Costs**

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

DATED: July 1, 2019

DocuSigned by:
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ERIN R. KOCH-GOODMAN
Administrative Law Judge
Office of Administrative Hearings

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
MICHAEL C. BRUMMEL
Deputy Attorney General
State Bar No. 236116
California Department of Justice
2550 Mariposa Mall, Room 5090
Fresno, CA. 93721
Telephone: (559) 705-2307
Facsimile: (559) 445-5106
E-mail: Michael.Brummel@doj.ca.gov

Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Carolyn Joan Rose, M.D.** **PO BOX 1210** **Mariposa, CA 95338** **Physician's and Surgeon's Certificate No. A 41263,** Respondent.	Case No. 800-2016-019796 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about October 9, 1984, the Medical Board issued Physician's and Surgeon's Certificate No. A 41263 to Carolyn Joan Rose, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2020, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

". . .

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

5. Section 2234 of the Code states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

". . ."

6. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent has subjected her Physician's and Surgeon's License No. A 41263 to disciplinary action under section 2227, as defined by section 2234, subdivision (b), of the Code, in that she committed multiple acts and/or omissions constituting gross negligence. The circumstances are as follows:

8. The investigation against Respondent was initiated after the California Highway Patrol notified the Board that they had arrested one of Respondent's patients for driving while impaired. During the investigation, officers discovered controlled substances in the possession of the patient that were prescribed by Respondent. A subsequent review by the Board of the Controlled Substances Utilization and Review System (CURES[1]) report for Respondent raised concerns about Respondent's prescribing practices.

[1] Controlled Substance Utilization Review and Evaluation System 2.0 (CURES) is a database of Schedule II, III and IV controlled substance prescriptions dispensed in California serving the public health, regulatory and oversight agencies and law enforcement. CURES 2.0 is committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care.

PATIENT A[2]

9. On or about July 17, 2015, Respondent had an appointment with Patient A, a then 64-year-old female. Patient A presented with a complicated prior medical history that included hypothyroidism, arthritis, melanoma, obesity, chronic sinusitis, oral herpes, insomnia, anxiety, allergies, emphysema, chronic back pain, degenerative disc disease, and sciatica. Her social history included a history of smoking, and she denied using alcohol. Patient A was prescribed numerous non-controlled medications for chronic health conditions, in addition to over-the-counter supplements.

10. Respondent served as Patient A's primary care physician, and saw her approximately once each month to refill her pain medications, manage her chronic conditions and provide preventative care. Patient A complained of chronic back pain and sciatica symptoms. Respondent typically entered the chief compliant as "pain management." Respondent routinely copied the history of presenting illness in the medical record from prior medical records, with only minor changes made to the severity of the pain reported by the patient. Respondent's medical records for the physical examination were nearly identical at each visit. Respondent did not document a neurological examination related to Patient A's pain symptoms or disc disease. Respondent never documented Patient A's mentation or affect. Respondent's medical records for Patient A are sparse and are largely repeated verbatim at each visit. Respondent failed to include comments in the medical record relating to the side effects of medications, the patient's function while on medications, and long-term goals for treating the pain. Respondent did not refer and/or document referral of Patient A to physical therapy for her back pain.

11. On or about August 24, 2015, Patient A was evaluated by a pain management specialist who recommended that she continue to receive epidural injections for her back pain.

12. Respondent did not discuss and/or document discussion of the risks of pain medications prescribed to Patient A. Respondent did not utilize a pain management agreement[3]

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[2] To protect the privacy of patients, individual names are not identified in this Accusation.

[3] Also known as a pain contract or controlled substance agreement. A pain management agreement is recommended for patients on short-acting opioids at the time of the third visit; on long acting opioids; or, expected to require more than three months of opioids. A pain

with Patient A. Respondent did not utilize CURES in the monitoring and treatment of Patient A while prescribing controlled substances.

13. On or about July 21, 2015, Respondent performed a mammogram for Patient A. Respondent never performed an electrocardiogram, electromyography, nerve study, or arranged for a surgical evaluation. Respondent did not document any discussion or consideration of influenza vaccinations, lipid screening, cervical cancer screening, colon cancer screening, Hepatitis C screening, osteoporosis screening or treatment of Patient A's obesity. Respondent did not document any information regarding the history of Patient A's hypothyroidism.

14. Respondent did not document any examination of Patient A's thyroid or a discussion of any thyroid or liver test results. Respondent did not document any history of presenting illness relating to Patient A's treatment of anxiety, depression, or insomnia. Respondent did not document any information regarding Patient A's mood, sleep hygiene, exercise, counseling, suicidal ideation, or a physical examination of her mentation or affect. Respondent did not document any information regarding Patient A's alcohol or caffeine use to supplement the patient's self-reported history.

15. Respondent provided Patient A with near monthly prescriptions for Morphine Sulfate[4] 100 mg (#90), Methadone[5] HCL 10 mg (#90), and Carisoprodol[6] 350 mg (#120).

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management agreement outlines the responsibilities of the physician and patient during the time that controlled substances are prescribed. See Medical Board of California: Guidelines for Prescribing Controlled Substances for Pain, November 2014.

[4] Morphine sulfate (Roxanol®) is a narcotic analgesic used to treat pain. Morphine sulfate is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022.

[5] Methadone is an opioid medication that has a high potential for abuse. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055 of the Health and Safety Code. Methadone is used as a pain reliever and as part of drug addiction detoxification and maintenance programs. It may cause a prolonged QT interval (a rare heart problem that may cause irregular heartbeat, fainting, or sudden death).

[6] Carisoprodol (Soma®) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed as indicated, it is used for the treatment of acute and painful musculoskeletal conditions. According to the DEA, Office of Diversion Control, "[c]arisoprodol abuse has escalated in the last decade in the United States…According to Diversion Drug Trends, published by the Drug Enforcement Administration (DEA) on the trends in diversion of controlled and non-controlled pharmaceuticals, carisoprodol

According to the CURES report for Patient A, during the period of on or about June 25, 2015, through on or about December 31, 2015, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
6/25/2015	MORPHINE SULFATE	100 MG	90	ROSE, CAROLYN J MD
6/26/2015	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
7/2/2015	METHADONE HCL	10 MG	90	ROSE, CAROLYN J MD
7/25/2015	MORPHINE SULFATE	100 MG	90	ROSE, CAROLYN J MD
7/25/2015	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
8/4/2015	METHADONE HCL	10 MG	90	ROSE, CAROLYN J MD
8/25/2015	MORPHINE SULFATE	100 MG	60	ROSE, CAROLYN J MD
8/25/2015	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
9/4/2015	METHADONE HCL	10 MG	90	ROSE, CAROLYN J MD
9/25/2015	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
9/25/2015	MORPHINE SULFATE	100 MG	60	ROSE, CAROLYN J MD
10/3/2015	METHADONE HCL	10 MG	90	ROSE, CAROLYN J MD
10/30/2015	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
10/30/2015	MORPHINE SULFATE	100 MG	60	ROSE, CAROLYN J MD
11/13/2015	METHADONE HCL	10 MG	90	ROSE, CAROLYN J MD
11/28/2015	MORPHINE SULFATE	100 MG	60	ROSE, CAROLYN J MD
11/28/2015	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
12/21/2015	OXYCODONE[7] HCL	30 MG	150	ROSE, CAROLYN J MD
12/21/2015	METHADONE HCL	10 MG	90	ROSE, CAROLYN J MD

16. Respondent continued to see Patient A on an approximately monthly basis for refills of her medications. Respondent's documentation and treatment of Patient A remained largely

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continues to be one of the most commonly diverted drugs. Diversion and abuse of carisoprodol is prevalent throughout the country. As of March 2011, street prices for [carisoprodol] Soma® ranged from $1 to $5 per tablet. Diversion methods include doctor shopping for the purposes of obtaining multiple prescriptions and forging prescriptions."

[7] Oxycodone (Oxaydo®, OxyCONTIN®, Oxyfast®, Roxicodon®, Xtampza ER®) is a white odorless crystalline power derived from an opium alkaloid. It is a pure agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of Oxycodone include anxiolysis, euphoria and feelings of relaxation. Oxycodone has a high potential for abuse. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022. Respiratory depression is the chief hazard from all opioid agonist preparations. Oxycodone should be used with caution and started in a reduced dosage (1/3 to ½ of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers and alcohol.

unchanged. Respondent continued to prescribe multiple controlled substances and benzodiazepines[8] to Patient A during 2016 with minor changes to the brand of drug prescribed.

17. On or about March 17, 2016 and on May 24, 2016, Respondent ordered labs for Patient A. On or about April 15, 2016, Patient A had her only documented toxicology screening. The test was positive for benzodiazepines, methadone, opiates, and oxycodone. Respondent did not document any mention or discussion of the test with Patient A in the medical records.

18. On or about November 11, 2016, Patient A had an MRI, which revealed degenerative disc disease without any mass lesions or disc bulges significant enough to require surgery.

19. According to the CURES report for Patient A, during the period of on or about January 1, 2016, through on or about December 31, 2016, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
1/2/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
2/1/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
2/2/2016	METHADONE HCL	10 MG	90	ROSE, CAROLYN J MD
2/2/2016	OXYCODONE HCL	30 MG	150	ROSE, CAROLYN J MD
2/29/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
3/4/2016	OXYCODONE HCL	30 MG	150	ROSE, CAROLYN J MD
3/4/2016	METHADONE HCL	10 MG	90	ROSE, CAROLYN J MD
3/11/2016	TEMAZEPAM[9]	30 MG	30	ROSE, CAROLYN J MD
3/31/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
4/2/2016	METHADONE HCL	10 MG	90	ROSE, CAROLYN J MD
4/2/2016	OXYCODONE HCL	30 MG	150	ROSE, CAROLYN J MD
4/9/2016	TEMAZEPAM	30 MG	30	ROSE, CAROLYN J MD
4/30/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
4/30/2016	METHADONE HCL	10 MG	90	ROSE, CAROLYN J MD
5/6/2016	OXYCODONE HCL	30 MG	150	ROSE, CAROLYN J MD
5/9/2016	TEMAZEPAM	30 MG	30	ROSE, CAROLYN J MD

[8] Benzodiazepines are a class of agents that work on the central nervous system, acting on select receptors in the brain that inhibit or reduce the activity of nerve cells within the brain. Valium, diazepam alprazolam and temazepam are all examples of benzodiazepines.

[9] Temazepam (Restoril®) is a benzodiazepine medication that affects chemicals in the brain that may be unbalanced in people with sleep problems. Temazepam is used to treat insomnia symptoms and has the potential for abuse. Temazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
5/13/2016	OPANA ER[10]	30 MG	60	ROSE, CAROLYN J MD
5/13/2016	NUCYNTA[11]	100 MG	150	ROSE, CAROLYN J MD
5/28/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
6/8/2016	TEMAZEPAM	30 MG	30	ROSE, CAROLYN J MD
6/10/2016	OPANA ER	40 MG	60	ROSE, CAROLYN J MD
6/10/2016	NUCYNTA	100 MG	180	ROSE, CAROLYN J MD
6/30/2016	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
7/8/2016	OXYCODONE HCL	30 MG	150	ROSE, CAROLYN J MD
7/29/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
8/6/2016	OXYCODONE HCL	30 MG	150	ROSE, CAROLYN J MD
8/13/2016	TEMAZEPAM	30 MG	30	ROSE, CAROLYN J MD
8/29/2016	CARISOPRODOL	350 MG	120	H.B. (PA)
9/7/2016	FENTANYL[12] TRANSDERMAL SYSTEM	75 MCG/1 HR	10	ROSE, CAROLYN J MD
9/7/2016	OXYCODONE HCL	30 MG	180	ROSE, CAROLYN J MD
9/12/2016	TEMAZEPAM	30 MG	30	ROSE, CAROLYN J MD
9/28/2016	CARISOPRODOL	350 MG	120	H.B. (PA)
10/10/2016	OXYCODONE HCL	30 MG	165	ROSE, CAROLYN J MD
10/21/2016	TEMAZEPAM	30 MG	30	ROSE, CAROLYN J MD
10/28/2016	CARISOPRODOL	350 MG	120	H.B. (PA)
11/7/2016	METHADONE HCL	10 MG	90	ROSE, CAROLYN J MD
11/19/2016	TEMAZEPAM	30 MG	30	ROSE, CAROLYN J MD

[10] Opana ER® (oxymorphone HCL), an opioid analgesic, is a is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of pain that is severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are not available. The Drug Enforcement Administration has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The Federal Drug Administration has issued a black box warning for Opana ER®, which warns about, among other things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress. The warning also cautions about the risks associated with concomitant use of Opana ER® with benzodiazepines or other central nervous system (CNS) depressants.

[11] Nucynta (tapentadol hydrochloride) is an opioid pain medication or narcotic that is used to treat moderate to severe pain. Nucynta has a high potential for abuse. Nucynta is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022.

[12] Fentanyl is an opioid skin patch that is used to treat severe chronic pain. Fentanyl has a high potential for abuse. Fentanyl is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022.

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
11/23/2016	BUTRANS[13]	10 MCG/1 HR	4	ROSE, CAROLYN J MD
12/2/2016	CARISOPRODOL	350 MG	120	H.B. (PA)
12/7/2016	BELSOMRA[14]	10 MG	60	ROSE, CAROLYN J MD
12/7/2016	OXYCODONE HCL	30 MG	165	ROSE, CAROLYN J MD
12/7/2016	FENTANYL TRANSDERMAL SYSTEM	100 MCG/1 HR	10	ROSE, CAROLYN J MD
12/12/2016	TEMAZEPAM	30 MG	30	ROSE, CAROLYN J MD

20. According to the CURES report for Patient A, during the period of on or about January 1, 2017, through on or about March 29, 2017, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
1/3/2017	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	20	J.L. DO
1/4/2017	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
1/6/2017	METHADONE HCL	10 MG	90	ROSE, CAROLYN J MD
1/6/2017	OXYCODONE HCL	30 MG	180	ROSE, CAROLYN J MD
1/11/2017	TEMAZEPAM	30 MG	30	ROSE, CAROLYN J MD
2/3/2017	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
2/3/2017	HYDROMORPHONE HCL	4 MG	150	ROSE, CAROLYN J MD
2/3/2017	FENTANYL TRANSDERMAL SYSTEM	100 MCG/1 HR	10	ROSE, CAROLYN J MD
2/23/2017	OXYCODONE HCL	30 MG	120	E.K.
3/4/2017	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
3/14/2017	MORPHINE SULFATE	10 MG/5 ML	100	ROSE, CAROLYN J MD
3/14/2017	FENTANYL TRANSDERMAL SYSTEM	100 MCG/1 HR	15	ROSE, CAROLYN J MD
3/20/2017	OXYCODONE HCL	30 MG	120	ROSE, CAROLYN J MD
3/21/2017	FENTANYL TRANSDERMAL SYSTEM	50 MCG/1 HR	5	ROSE, CAROLYN J MD

[13] Butrans® (buprenorphine hydrochloride) is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of opioid addiction and should be used as part of a complete treatment plan to include counseling and psychosocial services.

[14] Belsomra® (suvorexant) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of insomnia.

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
3/22/2017	MORPHINE SULFATE	10 MG/5 ML	200	ROSE, CAROLYN J MD
3/24/2017	LORAZEPAM[15] INTENSOL	2 MG/1 ML	30	R.R. MD
3/24/2017	MORPHINE SULFATE	20 MG/1 ML	30	R.R. MD
3/27/2017	LORAZEPAM INTENSOL	2 MG/1 ML	30	R.R. MD
3/27/2017	MORPHINE SULFATE	20 MG/1 ML	30	R.R. MD
3/28/2017	MORPHINE SULFATE	25 MG/1 ML	40	ROSE, CAROLYN J MD
3/29/2017	LORAZEPAM INTENSOL	2 MG/1 ML	30	R.R. MD
3/29/2017	MORPHINE SULFATE	10 MG/1 ML	25	ROSE, CAROLYN J MD

21. During the treatment period, Respondent did not provide Patient A informed consent regarding the risks of methadone. Respondent did not elicit an adequate family history of heart rhythm abnormalities for Patient A prior to prescribing methadone. Respondent did not adequately provide EKG monitoring for Patient A during the time she was prescribed methadone. Respondent failed to consider the risk of developing a prolonged QT interval when prescribing other medications in combination with methadone. Respondent failed to adequately document potential medication interactions with methadone. Respondent did not monitor Patient A for QT prolongation, even when she was prescribing medications that are known to prolong the QT interval. Respondent was unaware of the cardiac risks for prescribing methadone. Respondent was unaware of the need to monitor a patient's EKG while they are prescribed methadone.

22. Respondent did not offer Patient A safer alternatives to narcotics to treat her pain. Respondent did not refer Patient A for surgical evaluation, nerve ablation, spinal cord stimulators or attempt to decrease the amount of narcotic medications prescribed. Respondent did not utilize CURES reports in the treatment of Patient A. Respondent did not utilize a pain management agreement in the treatment of Patient A.

23. Respondent did not provide informed consent to Patient A regarding the risks of high dose narcotics. Respondent did not provide informed consent to Patient A regarding the risks of taking additional medications such as benzodiazepines in combination with high dose narcotics.

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[15] Lorazepam (Ativan®) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an anti-anxiety medication in the benzodiazepine family.

24. Respondent did not adequately utilize toxicology screening in the treatment of Patient A. Respondent did not document sufficient justification for the narcotics prescribed or for the subsequent changes made in the type of narcotics prescribed to Patient A. Respondent did not adequately document Patient A's functional status or her treatment goals. Respondent prescribed opiates totaling 465 MME/day[16], well in excess of the recommended 90 MME/day. Respondent did not screen Patient A for Opiate Dependence Disorder.

25. Despite prescribing Nucynta to Patient A, Respondent lacked knowledge about the nature and appropriate use of Nucynta. Respondent was unaware that Nucynta can elevate serotonin levels and can be dangerous if prescribed in combination with selective serotonin reuptake inhibitors (SSRIs)[17]. Respondent prescribed Patient A Nucynta in combination with SSRI's.

26. Respondent committed gross negligence in the care and treatment of Patient A, which included, but was not limited to the following:

A. Paragraphs 9 through 25, are hereby incorporated by reference as if fully set forth herein;

B. Respondent inappropriately prescribed methadone and/or managed Patient A while prescribing methadone; and

C. Respondent inappropriately prescribed controlled substances and/or managed Patient A while prescribing controlled substances.

PATIENT B

27. On or about August 10, 2015, Respondent had an appointment with Patient B, a then 62-year-old female. Patient B presented with a prior history that included chronic neck pain, migraines, muscle spasms, and a family history of colon cancer. Patient B denied smoking, and

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[16] MME is an abbreviation for the Morphine Milligram Equivalents used to evaluate the levels of opioids prescribed to a patient. The CDC recommends avoiding or carefully justifying any dosage greater than 90 MME/day.

[17] SSRI is an acronym for selective serotonin reuptake inhibitors that are part of a class of drugs commonly referred to as antidepressants. SSRIs enhance the function of the nerve cells in the brain that regulate emotion and are commonly used to treat depression.

reported drinking alcohol occasionally. Patient B was already taking Soma, Klonopin[18] and Norco[19] when she presented to Respondent. Respondent saw Patient B approximately every two months, and provided new prescriptions for her chronic pain, migraines, anxiety, iron deficiency anemia, acute bronchitis, and epigastric pain. Respondent never referred Patient B to a mental health professional, despite Respondent's impression that she suffered from anxiety.

28. According to the CURES report for Patient B, during the period of on or about June 29, 2015, through on or about December 31, 2015, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
6/29/2015	HYDROCODONE BITARTRATE-ACETAMINOPHEN[20]	325 MG-5 MG	180	ROSE, CAROLYN J MD
6/29/2015	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
7/3/2015	CLONAZEPAM	0.5 MG	90	ROSE, CAROLYN J MD
7/31/2015	CLONAZEPAM	0.5 MG	90	ROSE, CAROLYN J MD
7/31/2015	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
8/10/2015	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	180	ROSE, CAROLYN J MD
9/3/2015	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
9/3/2015	CLONAZEPAM	0.5 MG	90	ROSE, CAROLYN J MD
9/28/2015	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	180	ROSE, CAROLYN J MD
10/3/2015	CLONAZEPAM	0.5 MG	90	ROSE, CAROLYN J MD
10/3/2015	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
11/2/2015	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD

[18] Klonopin® (clonazepam) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an anti-anxiety medication in the benzodiazepine family.

[19] Norco® (acetaminophen and hydrocodone bitartrate) is an opiate/narcotic medication that has a high potential for abuse. Norco is a Schedule II controlled substance under Health and Safety Code section 11055, and a Schedule II controlled substance under section 1308.12 of Title 21 of the Code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022.

[20] Hydrocodone Bitartrate – Acetaminophen is also known under the brand names of Lorcet®, Lortab®, Norco® and Vicodin®. Hydrocodone Bitartrate – Acetaminophen is an opioid pain medication used for relief from moderate to moderately severe pain and has a high potential for abuse. Vicodin is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
11/2/2015	CLONAZEPAM	0.5 MG	90	ROSE, CAROLYN J MD
11/10/2015	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	180	ROSE, CAROLYN J MD
12/7/2015	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
12/7/2015	CLONAZEPAM	0.5 MG	90	ROSE, CAROLYN J MD

29. On or about April 4, 2016, Patient B completed a toxicology screening that was positive for benzodiazepines and opiates. According to the CURES report for Patient B, during the period of on or about January 1, 2016, through on or about December 31, 2016, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
1/7/2016	CLONAZEPAM	0.5 MG	90	ROSE, CAROLYN J MD
1/8/2016	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
1/11/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	180	ROSE, CAROLYN J MD
2/9/2016	CLONAZEPAM	0.5 MG	90	ROSE, CAROLYN J MD
2/16/2016	CLONAZEPAM	0.5 MG	90	ROSE, CAROLYN J MD
3/1/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	180	ROSE, CAROLYN J MD
3/2/2016	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
3/8/2016	CLONAZEPAM	0.5 MG	90	ROSE, CAROLYN J MD
3/15/2016	CLONAZEPAM	0.5 MG	90	ROSE, CAROLYN J MD
4/4/2016	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
4/4/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	180	ROSE, CAROLYN J MD
4/6/2016	CLONAZEPAM	0.5 MG	90	ROSE, CAROLYN J MD
4/16/2016	CLONAZEPAM	0.5 MG	90	ROSE, CAROLYN J MD
5/3/2016	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
5/21/2016	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
5/23/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	180	ROSE, CAROLYN J MD
5/25/2016	CARISOPRODOL	350 MG	240	ROSE, CAROLYN J MD
5/25/2016	CLONAZEPAM	0.5 MG	240	ROSE, CAROLYN J MD
7/11/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	180	ROSE, CAROLYN J MD

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
7/26/2016	CLONAZEPAM	0.5 MG	240	ROSE, CAROLYN J MD
8/15/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	180	ROSE, CAROLYN J MD
8/19/2016	CARISOPRODOL	350 MG	240	ROSE, CAROLYN J MD
10/3/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	180	ROSE, CAROLYN J MD
11/5/2016	CARISOPRODOL	350 MG	240	ROSE, CAROLYN J MD
11/12/2016	CLONAZEPAM	0.5 MG	240	ROSE, CAROLYN J MD
11/22/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	180	ROSE, CAROLYN J MD
12/9/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-10 MG	60	ROSE, CAROLYN J MD

30. Respondent continued to see Patient B approximately every one to two months to provide refills on her medications. On or about April 4, 2017, Patient B signed her first pain management agreement with Respondent. Respondent ordered blood work for Patient B in January, February and May of 2017 that revealed mild anemia, low iron levels, elevated platelets, and a positive rheumatoid factor.

31. According to the CURES report for Patient B, during the period of on or about January 1, 2017, through on or about December 31, 2017, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
1/5/2017	CARISOPRODOL	350 MG	240	ROSE, CAROLYN J MD
1/8/2017	CLONAZEPAM	0.5 MG	240	ROSE, CAROLYN J MD
1/11/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	180	ROSE, CAROLYN J MD
2/28/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-10 MG	180	ROSE, CAROLYN J MD
3/29/2017	CLONAZEPAM	0.5 MG	240	ROSE, CAROLYN J MD
4/4/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	180	ROSE, CAROLYN J MD

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
5/31/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	180	ROSE, CAROLYN J MD
6/9/2017	CLONAZEPAM	0.5 MG	240	ROSE, CAROLYN J MD
6/26/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	120	ROSE, CAROLYN J MD
7/29/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	150	ROSE, CAROLYN J MD
8/16/2017	CLONAZEPAM	0.5 MG	90	ROSE, CAROLYN J MD
8/29/2017	CLONAZEPAM	0.5 MG	250	ROSE, CAROLYN J MD
9/13/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	135	ROSE, CAROLYN J MD
10/12/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-7.5 MG	50	R.G.
10/19/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	60	J.M. (MD)
11/1/2017	CLONAZEPAM	0.5 MG	90	ROSE, CAROLYN J MD
11/11/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	60	J.M. (MD)
11/24/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-5 MG	150	ROSE, CAROLYN J MD
12/7/2017	TRAMADOL[21] HCL	50 MG	60	R.B. DPM
12/17/2017	CLONAZEPAM	0.5 MG	250	ROSE, CAROLYN J MD

32. Respondent prescribed excessive quantities of benzodiazepines to Patient B for an unnecessarily prolonged duration. Respondent routinely provided Patient B with new prescriptions for benzodiazepines every two months. Despite the excessive quantities and the duration for which Patient B received prescriptions of benzodiazepines, Respondent remained unconcerned.

[21] Tramadol (Ultram®) is a narcotic like pain reliever used to treat severe pain. Tramadol has the potential for abuse. Tramadol is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

33. Respondent did not provide Patient B with informed consent regarding the risks of taking benzodiazepines. Respondent did not provide Patient B with informed consent regarding the risks of taking benzodiazepines in combination with opiates, alcohol, or other muscle relaxants. Respondent did not utilize a pain management agreement that included a discussion of the risks of taking benzodiazepines. Respondent did not refer Patient B to a mental health professional. Respondent did not attempt to treat Patient B with any less dangerous treatment options including SSRI's, Flexeril[22], physical therapy or counseling.

34. Respondent failed to document an adequate alcohol use history for Patient B. Respondent did not document any discussions with Patient B regarding the dangers of using alcohol while taking medications prescribed by Respondent. Respondent did not adequately document information in support of Patient B's anxiety and mental health issues in the medical records.

35. Respondent committed gross negligence in the care and treatment of Patient B, which included, but was not limited to the following:

A. Paragraphs 27 through 34, are hereby incorporated by reference as if fully set forth herein;

B. Respondent failed to perform an appropriate evaluation of Patient B's neck pain and failed to offer safer alternatives for the treatment of her neck pain; and

C. Respondent inappropriately prescribed benzodiazepines to Patient B.

PATIENT C

36. On or about July 1, 2015, Respondent had an appointment with Patient C, a then 68-year-old female. Patient C presented with a prior history that included chronic lumbar disc disease, chronic pain with muscle spasm, anxiety, insomnia, peptic ulcer disease, hypertension, gastroesophageal reflux disease, and fibrocystic breast disease. Patient C saw Respondent for medication refills approximately every one to two months. Respondent routinely prescribed

[22] Flexeril® (cyclobenzaprine) is a muscle relaxant. It works by blocking nerve impulses that are sent to your brain. It is used together with rest and physical therapy to treat skeletal muscle conditions such as pain or injury. Flexeril is a dangerous drug as defined in Section 4022.

buspirone[23] for anxiety, gabapentin[24], Toradol[25] injections for back pain, Lisinopril for blood pressure, pantoprazole, ranitidine, omeprazole for ulcer disease and anti nausea medications. Respondent prescribed numerous controlled substances to Patient C, including alprazolam[26], lorazepam, baclofen[27], cyclobenzaprine, fentanyl, methocarbamol[28], oxycodone-acetaminophen, temazepam and zolpidem[29]. Respondent prescribed a combination of muscle relaxants, opiates, sedatives and benzodiazepines to Patient C concomitantly. Patient C also received treatment from a gastroenterologist for bleeding ulcers and nausea. Respondent described Patient C as hysterical and difficult to deal with. Respondent stated that she had "almost died several times with severe anemia" and "had a major problem with ulcers." Respondent stated that she tried to reduce her oxycodone, but "could not convince this lady well to do [sic]. But I'm learning now that I can't listen to them. I have to just do it anyway, okay. So she wasn't willing...and immediately the next month wanted to go back up again which I did, which was a mistake, okay, so, and that's where she stayed 'til she died." Respondent stated that Patient C was "on a lot of – too many medicines..."

37. On or about October 22, 2015, Respondent received a letter from United Healthcare regarding their concerns about the medications prescribed to Patient C. Specifically, United

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[23] BuSpar® (buspirone) is an anti-anxiety medicine that affects chemicals in the brain in people with anxiety. BuSpar is a dangerous drug as defined in Business and Professions Code section 4022.

[24] Gabapentin (Neurontin®) is an anti-epileptic medication also called an anticonvulsant. It affects chemicals and nerves in the body that are involved in the cause of seizures and some types of pain. Gabapentin is a dangerous drug as defined in Section 4022.

[25] Toradol® is a brand name for ketorolac. It is a nonsteroidal anti-inflammatory drug that works by reducing hormones that cause inflammation and pain in the body. Ketorolac is a dangerous drug as defined in Section 4022.

[26] Xanax® (alprazolam) is in the class of benzodiazepine medications. It affects chemicals in the brain that may be unbalanced in people with anxiety. Xanax is used to treat anxiety disorders, panic disorders and anxiety caused by depression. Xanax has the potential for abuse. Xanax is a Schedule IV controlled substance pursuant to health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[27] Baclofen is a muscle relaxant and is a dangerous drug as defined in Section 4022.

[28] Methocarbamol (Robaxin®) is a muscle relaxant. It is a dangerous drug as defined in Section 4022.

[29] Ambien® (zolpidem tartrate), a centrally acting hypnotic-sedative, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed as indicated, it is used for the short-term treatment of insomnia characterized by difficulties with sleep initiation.

Healthcare expressed concern for polypharmacy due to Respondent's concomitant prescribing of alprazolam and lorazepam, as well as the high daily dose of opioids prescribed in excess of 200 MME/day. Respondent did not document ever reviewing the letter, considering the warning or discussing the letter with Patient C.

38. On or about November 25, 2015 and on or about July 23, 2015, Respondent received two separate letters from United Healthcare inquiring about the high doses of opiates Respondent was prescribing to Patient C. The letters identified Respondent's prescribing to Patient C as an issue of concern because of the high daily dose of opioids in excess of 200 MME/day. Respondent did not document ever reviewing the letters, considering the warning or discussing the letter with Patient C. Respondent made no changes to the prescribing for Patient C at the following visits.

39. According to the CURES report for Patient C, during the period of on or about June 6, 2015, through on or about December 31, 2015, Patient C filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
6/6/2015	ZOLPIDEM TARTRATE	5 MG	30	ROSE, CAROLYN J MD
6/8/2015	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	120	ROSE, CAROLYN J MD
6/10/2015	LORAZEPAM	1 MG	60	ROSE, CAROLYN J MD
6/30/2015	ALPRAZOLAM	0.5 MG	60	ROSE, CAROLYN J MD
7/1/2015	FENTANYL TRANSDERMAL SYSTEM	100 MCG/1 HR	10	ROSE, CAROLYN J MD
7/5/2015	ZOLPIDEM TARTRATE	5 MG	30	ROSE, CAROLYN J MD
7/7/2015	LORAZEPAM	1 MG	60	ROSE, CAROLYN J MD
7/7/2015	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	120	ROSE, CAROLYN J MD
7/22/2015	ALPRAZOLAM	0.5 MG	60	ROSE, CAROLYN J MD
8/3/2015	LORAZEPAM	1 MG	90	ROSE, CAROLYN J MD
8/3/2015	FENTANYL TRANSDERMAL SYSTEM	100 MCG/1 HR	10	ROSE, CAROLYN J MD
8/4/2015	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	120	ROSE, CAROLYN J MD
8/4/2015	ZOLPIDEM TARTRATE	5 MG	30	ROSE, CAROLYN J MD
8/21/2015	ALPRAZOLAM	0.5 MG	60	ROSE, CAROLYN J MD

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
9/1/2015	LORAZEPAM	1 MG	90	ROSE, CAROLYN J MD
9/1/2015	FENTANYL TRANSDERMAL SYSTEM	100 MCG/1 HR	10	ROSE, CAROLYN J MD
9/1/2015	ZOLPIDEM TARTRATE	5 MG	30	ROSE, CAROLYN J MD
9/3/2015	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	120	ROSE, CAROLYN J MD
9/18/2015	ALPRAZOLAM	0.5 MG	90	ROSE, CAROLYN J MD
10/1/2015	ZOLPIDEM TARTRATE	5 MG	30	ROSE, CAROLYN J MD
10/1/2015	LORAZEPAM	1 MG	90	ROSE, CAROLYN J MD
10/2/2015	FENTANYL	100 MCG/1 HR	10	ROSE, CAROLYN J MD
10/2/2015	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	120	ROSE, CAROLYN J MD
10/12/2015	ALPRAZOLAM	0.5 MG	90	ROSE, CAROLYN J MD
10/30/2015	LORAZEPAM	1 MG	90	ROSE, CAROLYN J MD
10/30/2015	ZOLPIDEM TARTRATE	5 MG	30	ROSE, CAROLYN J MD
11/3/2015	FENTANYL	100 MCG/1 HR	10	ROSE, CAROLYN J MD
11/3/2015	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	150	ROSE, CAROLYN J MD
11/4/2015	ALPRAZOLAM	0.5 MG	90	ROSE, CAROLYN J MD
11/17/2015	ZOLPIDEM TARTRATE	10 MG	30	ROSE, CAROLYN J MD
11/23/2015	LORAZEPAM	1 MG	90	ROSE, CAROLYN J MD
12/3/2015	ALPRAZOLAM	0.5 MG	90	ROSE, CAROLYN J MD
12/4/2015	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	150	ROSE, CAROLYN J MD
12/4/2015	FENTANYL TRANSDERMAL SYSTEM	100 MCG/1 HR	10	ROSE, CAROLYN J MD
12/17/2015	ZOLPIDEM TARTRATE	10 MG	30	ROSE, CAROLYN J MD
12/21/2015	LORAZEPAM	1 MG	90	ROSE, CAROLYN J MD

40. In March, May, and July of 2016, Respondent prescribed Patient B lorazepam and alprazolam concomitantly. On or about February 5, 2016, Respondent increased the prescription of Percocet[30] to 180 pills per month. On or about March of 2016, Respondent increased the Fentanyl from every 3 days to every 2 days.

[30] Percocet® (oxycodone and acetaminophen) from the opioid class of medications, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed as indicated, it is used for the treatment of moderate to moderately severe

41. According to the CURES report for Patient C, during the period of on or about January 1, 2016, through on or about December 31, 2016, Patient C filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
1/3/2016	ALPRAZOLAM	0.5 MG	90	ROSE, CAROLYN J MD
1/4/2016	FENTANYL TRANSDERMAL SYSTEM	100 MCG/1 HR	10	ROSE, CAROLYN J MD
1/4/2016	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	120	ROSE, CAROLYN J MD
1/17/2016	ZOLPIDEM TARTRATE	10 MG	30	ROSE, CAROLYN J MD
1/19/2016	LORAZEPAM	1 MG	90	ROSE, CAROLYN J MD
1/29/2016	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	30	J.A. MD
1/29/2016	FENTANYL	100 MCG/1 HR	3	J.A. MD
2/4/2016	ZOLPIDEM TARTRATE	5 MG	40	M.L. MD
2/4/2016	ALPRAZOLAM	0.5 MG	90	ROSE, CAROLYN J MD
2/5/2016	FENTANYL TRANSDERMAL SYSTEM	100 MCG/1 HR	10	ROSE, CAROLYN J MD
2/5/2016	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	180	ROSE, CAROLYN J MD
2/13/2016	ZOLPIDEM TARTRATE	10 MG	30	ROSE, CAROLYN J MD
2/29/2016	ALPRAZOLAM	0.5 MG	90	ROSE, CAROLYN J MD
3/1/2016	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	180	ROSE, CAROLYN J MD
3/1/2016	FENTANYL TRANSDERMAL SYSTEM	100 MCG/1 HR	15	ROSE, CAROLYN J MD
3/16/2016	ZOLPIDEM TARTRATE	10 MG	30	ROSE, CAROLYN J MD
3/25/2016	LORAZEPAM	1 MG	90	ROSE, CAROLYN J MD
3/28/2016	ALPRAZOLAM	0.5 MG	90	ROSE, CAROLYN J MD
4/1/2016	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	180	ROSE, CAROLYN J MD
4/1/2016	FENTANYL	100 MCG/1 HR	15	ROSE, CAROLYN J MD
4/21/2016	LORAZEPAM	1 MG	90	ROSE, CAROLYN J MD
4/21/2016	ZOLPIDEM TARTRATE	10 MG	30	ROSE, CAROLYN J MD
5/2/2016	FENTANYL	100 MCG/1 HR	10	ROSE, CAROLYN J MD
5/5/2016	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	180	ROSE, CAROLYN J MD
5/20/2016	LORAZEPAM	1 MG	90	ROSE, CAROLYN J MD

pain. The Drug Enforcement Administration (DEA) has identified opioids, such as Oxycodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 41.)

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
5/20/2016	ALPRAZOLAM	0.5 MG	90	ROSE, CAROLYN J MD
5/20/2016	ZOLPIDEM TARTRATE	10 MG	30	ROSE, CAROLYN J MD
6/5/2016	LORAZEPAM	2 MG	45	A.B. (MD)
6/7/2016	FENTANYL TRANSDERMAL SYSTEM	100 MCG/1 HR	10	ROSE, CAROLYN J MD
6/7/2016	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	180	ROSE, CAROLYN J MD
6/7/2016	ALPRAZOLAM	1 MG	90	ROSE, CAROLYN J MD
6/20/2016	ZOLPIDEM TARTRATE	10 MG	30	ROSE, CAROLYN J MD
7/4/2016	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	180	ROSE, CAROLYN J MD
7/4/2016	ALPRAZOLAM	1 MG	90	ROSE, CAROLYN J MD
7/4/2016	FENTANYL TRANSDERMAL SYSTEM	100 MCG/1 HR	10	ROSE, CAROLYN J MD
7/19/2016	LORAZEPAM	1 MG	90	ROSE, CAROLYN J MD
7/19/2016	ZOLPIDEM TARTRATE	10 MG	30	ROSE, CAROLYN J MD
8/8/2016	ALPRAZOLAM	1 MG	90	ROSE, CAROLYN J MD
8/8/2016	FENTANYL	100 MCG/1 HR	10	ROSE, CAROLYN J MD
8/8/2016	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	180	ROSE, CAROLYN J MD
9/1/2016	ZOLPIDEM TARTRATE	10 MG	30	ROSE, CAROLYN J MD
9/2/2016	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	170	ROSE, CAROLYN J MD
9/5/2016	FENTANYL	100 MCG/1 HR	10	ROSE, CAROLYN J MD
9/6/2016	ALPRAZOLAM	1 MG	90	ROSE, CAROLYN J MD
10/4/2016	ZOLPIDEM TARTRATE	10 MG	30	ROSE, CAROLYN J MD
10/4/2016	ALPRAZOLAM	1 MG	90	ROSE, CAROLYN J MD
10/4/2016	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	160	ROSE, CAROLYN J MD
10/4/2016	FENTANYL TRANSDERMAL SYSTEM	100 MCG/1 HR	10	ROSE, CAROLYN J MD
11/2/2016	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	170	ROSE, CAROLYN J MD
11/2/2016	ALPRAZOLAM	1 MG	90	ROSE, CAROLYN J MD
11/2/2016	FENTANYL	100 MCG/1 HR	10	ROSE, CAROLYN J MD
11/2/2016	ZOLPIDEM TARTRATE	10 MG	30	ROSE, CAROLYN J MD
12/1/2016	ALPRAZOLAM	1 MG	90	ROSE, CAROLYN J MD
12/1/2016	ZOLPIDEM TARTRATE	10 MG	30	ROSE, CAROLYN J MD
12/2/2016	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	170	ROSE, CAROLYN J MD

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
12/2/2016	FENTANYL TRANSDERMAL SYSTEM	100 MCG/1 HR	10	ROSE, CAROLYN J MD

42. According to the CURES report for Patient C, during the period of on or about January 1, 2017, through on or about February 3, 2017, Patient C filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
1/2/2017	ALPRAZOLAM	1 MG	90	ROSE, CAROLYN J MD
1/2/2017	ZOLPIDEM TARTRATE	10 MG	30	ROSE, CAROLYN J MD
1/4/2017	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	170	ROSE, CAROLYN J MD
1/4/2017	FENTANYL TRANSDERMAL SYSTEM	100 MCG/1 HR	10	ROSE, CAROLYN J MD
2/1/2017	ALPRAZOLAM	1 MG	90	ROSE, CAROLYN J MD
2/1/2017	ZOLPIDEM TARTRATE	10 MG	30	ROSE, CAROLYN J MD
2/3/2017	OXYCODONE HCL-ACETAMINOPHEN	325 MG-10 MG	170	ROSE, CAROLYN J MD
2/3/2017	FENTANYL TRANSDERMAL SYSTEM	100 MCG/1 HR	10	ROSE, CAROLYN J MD

43. Respondent prescribed Patient C high-dose opiates for multiple years in excess of 320 MME/day. Respondent did not attempt to treat Patient C's pain with any less dangerous medications of interventions. Respondent did not refer Patient C to a physical therapist, interventionist or pain specialist. Respondent failed to utilize CURES in the treatment of Patient C. Respondent ignored warnings about polypharmacy and potential excessive prescribing raised by Patient C's insurance company. After receiving warnings about potential excessive prescribing of opiates from Patient C's insurance company, Respondent increased the amount of opiates prescribed during the following months. Respondent only performed three toxicology tests on Patient C from 2015 through 2017. The toxicology screening revealed that Patient C was not taking benzodiazepines that were being prescribed by Respondent and did not test for fentanyl. Respondent did not discuss or document discussion of the test results with Patient C. Respondent did not screen Patient C for opiate dependence disorder.

44. Respondent prescribed ketorolac, a nonsteroidal anti-inflammatory agent[31], to Patient C at almost every visit despite Patient C's history of ulcers and gastrointestinal problems. Respondent even gave Patient C an injection of ketorolac immediately after the patient's hospitalization for a bleeding duodenal ulcer. Respondent did not perform a single kidney function test on Patient C over two years of treatment.

45. Respondent committed gross negligence in the care and treatment of Patient C, which included, but was not limited to the following:

A. Paragraphs 36 through 44, are hereby incorporated by reference as if fully set forth herein;

B. Respondent inappropriately prescribed opiate medications to Patient C; and

C. Respondent inappropriately prescribed NSAIDs in a patient with known ulcer disease.

PATIENT E

46. On or about April 17, 2015, Respondent had an appointment with Patient E, a then 54-year-old female complaining of back pain. Patient E presented with a prior history that included neck pain, back pain, severe osteoporosis, anxiety, depression, hyponatremia, headaches, bleeding ulcers from NSAIDs, and vertebral factures. Patient E reported that she was a smoker, did not drink alcohol, and had a brother who died from alcoholism. Patient E was already taking oxycodone for pain when she started seeing Respondent, and was concurrently receiving treatment from a psychiatrist who prescribed benzodiazepines. At the first visit, Respondent prescribed Patient E oxycodone, tramadol and Soma.

47. Respondent saw Patient E approximately monthly for refills of medications including gabapentin, MS Contin[32], oxycodone, tramadol, Soma, Voltaren gel, Toradol injections, and venlafaxine[33]. Respondent provided Patient E referrals to counseling, neurosurgery, orthopedic

[31] Nonsteroidal anti-inflammatory agents or NSAIDs, are a group of medicines that relieve pain, fever, and reduce inflammation.

[32] MS Contin® is a brand name for morphine.

[33] Venlafaxine (Effexor XR®, Effexor®) is an antidepressant belonging to a group of drugs called selective serotonin and norepinephrine reuptake inhibitors. It affects chemicals in the brain, and is used to treat major depressive disorder, anxiety and panic disorder. Venlafaxine is a dangerous drug pursuant to Business and Professions Code section 4022.

surgery and recommended that she consider acupressure. Respondent described Patient E as "a very anxious person" and "somebody addicted to her medicines." Respondent admitted that it was a mistake to prescribe Patient E oxycodone and MS Contin at the same time. At the subject interview, when asked why she prescribed two short acting narcotics like oxycodone and tramadol at the same time, Respondent replied, "Oh, that wasn't good."

48. On or about May 20, 2015, Respondent received a letter from Patient E's insurance company inquiring about the two different antidepressants she was being prescribed simultaneously (duloxetine[34] and venlafaxine). Respondent did not document ever reviewing the letter, considering the warning or discussing the letter with Patient C.

49. On or about June 5, 2015, Patient E consulted with a neurosurgeon. The neurosurgeon performed CT scans, MRIs and placed an intrathecal Fentanyl pump.

50. On or about April 17, 2015, Respondent performed a toxicology screening on Patient E that was positive for oxycodone and benzodiazepines.

51. According to the CURES report for Patient E, during the period of on or about June 6, 2015, through on or about December 31, 2015, Patient E filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
6/6/2015	ZOLPIDEM TARTRATE	10 MG	30	G.I. MD
6/10/2015	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
6/12/2015	OXYCODONE HCL	30 MG	180	ROSE, CAROLYN J MD
6/12/2015	MORPHINE SULFATE	60 MG	60	ROSE, CAROLYN J MD
6/17/2015	CLONAZEPAM	1 MG	90	G.I. MD
6/25/2015	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
7/5/2015	ZOLPIDEM TARTRATE	10 MG	30	G.I. MD
7/10/2015	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
7/11/2015	MORPHINE SULFATE	60 MG	60	ROSE, CAROLYN J MD

[34] Duloxetine (Cymbalta®, Irenka®) is a selective serotonin and norepinephrine reuptake inhibitor antidepressant. It affects chemicals in the brain that may be unbalanced in people with depression, and is used to treat major depressive disorder. Duloxetine is a dangerous drug pursuant to Business and Professions Code section 4022.

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
7/15/2015	CLONAZEPAM	1 MG	90	G.I. MD
7/15/2015	OXYCODONE HCL	30 MG	180	ROSE, CAROLYN J MD
7/26/2015	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
8/3/2015	ZOLPIDEM TARTRATE	10 MG	30	G.I. MD
8/9/2015	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
8/10/2015	OXYCODONE HCL	30 MG	180	ROSE, CAROLYN J MD
8/10/2015	MORPHINE SULFATE	60 MG	60	ROSE, CAROLYN J MD
8/13/2015	CLONAZEPAM	1 MG	90	G.I. MD
8/23/2015	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
9/3/2015	ZOLPIDEM TARTRATE	10 MG	30	G.I. MD
9/7/2015	MORPHINE SULFATE	100 MG	60	ROSE, CAROLYN J MD
9/7/2015	OXYCODONE HCL	30 MG	180	ROSE, CAROLYN J MD
9/7/2015	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
9/7/2015	CLONAZEPAM	1 MG	90	G.I. MD
9/20/2015	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
10/2/2015	ZOLPIDEM TARTRATE	10 MG	30	G.I. MD
10/5/2015	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
10/5/2015	CLONAZEPAM	1 MG	90	G.I. MD
10/5/2015	MORPHINE SULFATE	100 MG	60	ROSE, CAROLYN J MD
10/5/2015	OXYCODONE HCL	30 MG	180	ROSE, CAROLYN J MD
10/17/2015	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
11/1/2015	ZOLPIDEM TARTRATE	10 MG	30	G.I. MD
11/2/2015	OXYCODONE HCL	30 MG	180	ROSE, CAROLYN J MD
11/2/2015	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
11/2/2015	MORPHINE SULFATE	100 MG	60	ROSE, CAROLYN J MD
11/2/2015	CLONAZEPAM	1 MG	90	G.I. MD
11/15/2015	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
11/26/2015	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
11/26/2015	CLONAZEPAM	1 MG	90	G.I. MD
11/30/2015	MORPHINE SULFATE	100 MG	60	ROSE, CAROLYN J MD
11/30/2015	OXYCODONE HCL	30 MG	180	ROSE, CAROLYN J MD
12/13/2015	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
12/24/2015	CLONAZEPAM	1 MG	90	G.I. MD

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
12/27/2015	MORPHINE SULFATE	60 MG	60	ROSE, CAROLYN J MD
12/27/2015	OXYCODONE HCL	30 MG	180	ROSE, CAROLYN J MD

52. On or about April 15, 2016, Respondent performed a toxicology screening on Patient E that was positive for oxycodone and benzodiazepines. On or about March 7, 2016, Patient E underwent a vertebroplasty of her T6 vertebrae. On or about March 9, 2015, Patient E sought treatment from a pain specialist.

53. According to the CURES report for Patient E, during the period of on or about January 1, 2016, through on or about December 31, 2016, Patient E filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
1/2/2016	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
1/5/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
1/20/2016	CLONAZEPAM	1 MG	90	G.I. MD
1/25/2016	OXYCODONE HCL	30 MG	180	ROSE, CAROLYN J MD
1/25/2016	MORPHINE SULFATE	60 MG	60	ROSE, CAROLYN J MD
1/30/2016	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
2/8/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
2/15/2016	CLONAZEPAM	1 MG	90	G.I. MD
2/16/2016	MORPHINE SULFATE	100 MG	60	ROSE, CAROLYN J MD
2/26/2016	OXYCODONE HCL	30 MG	150	ROSE, CAROLYN J MD
3/5/2016	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
3/7/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
3/15/2016	MORPHINE SULFATE	100 MG	60	ROSE, CAROLYN J MD
3/16/2016	CLONAZEPAM	1 MG	90	G.I. MD
3/18/2016	OXYCODONE HCL	30 MG	150	ROSE, CAROLYN J MD
4/2/2016	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
4/4/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
4/13/2016	CLONAZEPAM	1 MG	90	G.I. MD
4/15/2016	OXYCODONE HCL	30 MG	150	ROSE, CAROLYN J MD
4/15/2016	MORPHINE SULFATE	100 MG	60	ROSE, CAROLYN J MD
4/29/2016	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
5/3/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
5/12/2016	CLONAZEPAM	1 MG	90	G.I. MD
5/13/2016	OXYCODONE HCL	30 MG	150	ROSE, CAROLYN J MD
5/13/2016	MORPHINE SULFATE	100 MG	60	ROSE, CAROLYN J MD

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
5/27/2016	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
6/1/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
6/8/2016	OXYCODONE HCL	30 MG	120	ROSE, CAROLYN J MD
6/10/2016	CLONAZEPAM	1 MG	90	G.I. MD
6/10/2016	MORPHINE SULFATE	100 MG	60	ROSE, CAROLYN J MD
6/25/2016	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
6/30/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
7/8/2016	MORPHINE SULFATE	100 MG	60	ROSE, CAROLYN J MD
7/8/2016	CLONAZEPAM	1 MG	90	G.I. MD
7/8/2016	OXYCODONE HCL	30 MG	120	ROSE, CAROLYN J MD
7/28/2016	TRAMADOL HCL	50 MG	50	R.R. MD
7/28/2016	OXYCODONE HCL	30 MG	105	R.R. MD
8/2/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
8/4/2016	CLONAZEPAM	1 MG	90	G.I. MD
8/7/2016	MORPHINE SULFATE	100 MG	60	ROSE, CAROLYN J MD
8/12/2016	TRAMADOL HCL	50 MG	50	R.R. MD
8/30/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
8/31/2016	MORPHINE SULFATE	80 MG	60	ROSE, CAROLYN J MD
8/31/2016	OXYCODONE HCL	30 MG	120	ROSE, CAROLYN J MD
9/3/2016	CLONAZEPAM	1 MG	90	G.I. MD
9/5/2016	TRAMADOL HCL	50 MG	50	R.R. MD
9/8/2016	MORPHINE SULFATE	30 MG	60	ROSE, CAROLYN J MD
9/26/2016	TRAMADOL HCL	50 MG	50	R.R. MD
9/28/2016	OXYCODONE HCL	30 MG	90	ROSE, CAROLYN J MD
9/28/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
9/28/2016	MORPHINE SULFATE	100 MG	60	ROSE, CAROLYN J MD
10/4/2016	CLONAZEPAM	1 MG	90	G.I. MD
10/16/2016	TRAMADOL HCL	50 MG	50	R.R. MD
10/21/2016	MORPHINE SULFATE	60 MG	60	ROSE, CAROLYN J MD
10/25/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
10/26/2016	OXYCODONE HCL	30 MG	90	ROSE, CAROLYN J MD
11/1/2016	CLONAZEPAM	1 MG	90	G.I. MD
11/10/2016	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
11/16/2016	MORPHINE SULFATE	80 MG	60	ROSE, CAROLYN J MD
11/16/2016	OXYCODONE HCL	15 MG	120	ROSE, CAROLYN J MD
11/23/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
11/29/2016	CLONAZEPAM	1 MG	90	G.I. MD
12/12/2016	MORPHINE SULFATE	80 MG	60	ROSE, CAROLYN J MD
12/14/2016	OXYCODONE HCL	15 MG	120	ROSE, CAROLYN J MD
12/14/2016	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
12/21/2016	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
12/28/2016	CLONAZEPAM	1 MG	90	G.I. MD

54. On or about February 6 and March 1, 2017, Respondent performed a toxicology screening on Patient E that was positive for oxycodone and benzodiazepines. On or about February 6, 2017, Patient E signed a pain management agreement.

55. According to the CURES report for Patient E, during the period of on or about January 1, 2017, through on or about December 31, 2017, Patient E filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
1/6/2017	OXYCODONE HCL	30 MG	150	ROSE, CAROLYN J MD
1/9/2017	MORPHINE SULFATE	80 MG	60	ROSE, CAROLYN J MD
1/18/2017	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
1/26/2017	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
1/26/2017	CLONAZEPAM	1 MG	90	G.I. MD
2/4/2017	OXYCODONE HCL	30 MG	18	M.A.
2/6/2017	MORPHINE SULFATE	80 MG	60	ROSE, CAROLYN J MD
2/6/2017	OXYCODONE HCL	30 MG	120	ROSE, CAROLYN J MD
2/16/2017	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
2/23/2017	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
2/23/2017	CLONAZEPAM	1 MG	90	G.I. MD
3/6/2017	OXYCODONE HCL	30 MG	135	ROSE, CAROLYN J MD
3/9/2017	MORPHINE SULFATE	80 MG	60	ROSE, CAROLYN J MD
3/15/2017	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
3/16/2017	ZOLPIDEM TARTRATE	5 MG	30	G.I. MD
3/24/2017	CLONAZEPAM	1 MG	90	G.I. MD
3/31/2017	OXYCODONE HCL	30 MG	150	ROSE, CAROLYN J MD
4/6/2017	MORPHINE SULFATE	80 MG	60	ROSE, CAROLYN J MD
4/15/2017	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
4/20/2017	ZOLPIDEM TARTRATE	5 MG	30	G.I. MD
4/22/2017	CLONAZEPAM	1 MG	90	G.I. MD
4/23/2017	OXYCODONE HCL	30 MG	150	ROSE, CAROLYN J MD
5/8/2017	MORPHINE SULFATE	80 MG	60	ROSE, CAROLYN J MD
5/14/2017	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
5/16/2017	OXYCODONE HCL	30 MG	135	ROSE, CAROLYN J MD
5/20/2017	CLONAZEPAM	1 MG	45	G.I. MD
5/24/2017	ZOLPIDEM TARTRATE	5 MG	30	G.I. MD
6/5/2017	CLONAZEPAM	1 MG	90	G.I. MD

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
6/5/2017	MORPHINE SULFATE	80 MG	60	ROSE, CAROLYN J MD
6/13/2017	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
6/14/2017	OXYCODONE HCL	30 MG	120	ROSE, CAROLYN J MD
7/3/2017	CLONAZEPAM	1 MG	90	G.I. MD
7/3/2017	MORPHINE SULFATE	80 MG	60	ROSE, CAROLYN J MD
7/12/2017	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
7/12/2017	OXYCODONE HCL	30 MG	120	ROSE, CAROLYN J MD
8/2/2017	CLONAZEPAM	1 MG	90	G.I. MD
8/2/2017	MORPHINE SULFATE	80 MG	56	ROSE, CAROLYN J MD
8/9/2017	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
8/9/2017	OXYCODONE HCL	30 MG	120	ROSE, CAROLYN J MD
8/29/2017	MORPHINE SULFATE	80 MG	60	ROSE, CAROLYN J MD
8/29/2017	CLONAZEPAM	1 MG	90	G.I. MD
9/6/2017	OXYCODONE HCL	30 MG	120	ROSE, CAROLYN J MD
9/6/2017	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
9/27/2017	CLONAZEPAM	1 MG	90	G.I. MD
9/28/2017	MORPHINE SULFATE	80 MG	60	ROSE, CAROLYN J MD
10/4/2017	OXYCODONE HCL	30 MG	120	ROSE, CAROLYN J MD
10/4/2017	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
10/25/2017	OXYCODONE HCL	20 MG	120	ROSE, CAROLYN J MD
10/25/2017	MORPHINE SULFATE	80 MG	60	ROSE, CAROLYN J MD
10/29/2017	CLONAZEPAM	1 MG	90	G.I. MD
11/5/2017	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
11/28/2017	MORPHINE SULFATE	60 MG	60	ROSE, CAROLYN J MD
11/28/2017	OXYCODONE HCL	20 MG	120	ROSE, CAROLYN J MD
11/29/2017	CLONAZEPAM	1 MG	90	G.I. MD
12/6/2017	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
12/20/2017	OXYCODONE HCL	20 MG	150	ROSE, CAROLYN J MD
12/28/2017	CLONAZEPAM	1 MG	90	G.I. MD
12/28/2017	MORPHINE SULFATE	60 MG	60	ROSE, CAROLYN J MD

56. According to the CURES report for Patient E, during the period of on or about January 1, 2018, through on or about June 3, 2018, Patient E filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
1/17/2018	OXYCODONE HCL	20 MG	150	ROSE, CAROLYN J MD
1/17/2018	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
1/26/2018	MORPHINE SULFATE	60 MG	60	ROSE, CAROLYN J MD

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
1/26/2018	CLONAZEPAM	1 MG	90	G.I. MD
2/13/2018	OXYCODONE HCL	20 MG	150	ROSE, CAROLYN J MD
2/16/2018	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
2/23/2018	CLONAZEPAM	1 MG	90	G.I. MD
2/23/2018	MORPHINE SULFATE	60 MG	60	ROSE, CAROLYN J MD
2/28/2018	CLONAZEPAM	0.5 MG	90	G.I. MD
3/13/2018	OXYCODONE HCL	20 MG	150	ROSE, CAROLYN J MD
3/18/2018	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
3/24/2018	MORPHINE SULFATE	60 MG	60	ROSE, CAROLYN J MD
4/10/2018	OXYCODONE HCL	20 MG	210	ROSE, CAROLYN J MD
4/16/2018	CLONAZEPAM	0.5 MG	90	G.I. MD
4/16/2018	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
4/24/2018	MORPHINE SULFATE	60 MG	60	ROSE, CAROLYN J MD
4/25/2018	CLONAZEPAM	1 MG	90	G.I. MD
5/9/2018	OXYCODONE HCL	20 MG	210	ROSE, CAROLYN J MD
5/14/2018	CARISOPRODOL	350 MG	120	ROSE, CAROLYN J MD
5/23/2018	MORPHINE SULFATE	60 MG	60	ROSE, CAROLYN J MD
6/3/2018	CLONAZEPAM	1 MG	90	G.I. MD

57. Respondent repeatedly administered ketorolac injections to Patient E during office visits, despite the documentation in the medical record that Patient E had a history of ulcers and a known allergy to NSAIDS. On or about July 5, 2017, the records document that the patient has a bleeding ulcer due to NSAIDs, and Respondent provided an NSAID injection of ketorolac at the same visit.

58. Respondent committed gross negligence in the care and treatment of Patient E, which included, but was not limited to the following:

A. Paragraphs 46 through 57, are hereby incorporated by reference as if fully set forth herein; and

B. Respondent inappropriately prescribed NSAID medications to Patient E.

PATIENT F

59. On or about July 7, 2015, Respondent had an appointment with Patient F, a then 62-year-old female complaining of back pain. Patient F presented with a prior history that included

hyperlipidemia, tremors, hypertension, emphysema, gastroesophageal reflux, knee and spine arthritis, spinal stenosis and allergies. Patient F reported that she previously smoked and occasionally drinks alcohol.

60. Respondent saw Patient F approximately every three months for chronic back pain and provided prescriptions for pain medications and benzodiazepines. Respondent's medical records for Patient F are minimal and do not contain sufficient information to support the diagnosis of degenerative disc disease. Respondent did not utilize a pain management agreement or review CURES in the treatment of Patient F. Respondent's records include a single toxicology screening for Patient F, performed in the emergency room, which was positive for opiates. At the subject interview, when asked about the reasoning in support of the concomitant prescriptions of soma and hydrocodone to Patient F, Respondent admitted that "[i]t's way too much sedation, way too much sedation."

61. According to the CURES report for Patient F, during the period of on or about June 30, 2015, through on or about December 31, 2015, Patient F filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
6/30/2015	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
7/8/2015	TRAMADOL HCL	50 MG	60	ROSE, CAROLYN J MD
8/6/2015	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
8/7/2015	TRAMADOL HCL	50 MG	60	ROSE, CAROLYN J MD
9/9/2015	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
9/9/2015	TRAMADOL HCL	50 MG	60	ROSE, CAROLYN J MD
9/10/2015	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-7.5 MG	120	ROSE, CAROLYN J MD
10/15/2015	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
11/9/2015	TRAMADOL HCL	50 MG	60	ROSE, CAROLYN J MD
11/12/2015	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
12/7/2015	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
12/11/2015	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-7.5 MG	150	ROSE, CAROLYN J MD

62. According to the CURES report for Patient F, during the period of on or about January 1, 2016, through on or about December 31, 2016, Patient F filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
1/6/2016	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
1/13/2016	PROMETHAZINE HCL-CODEINE PHOSPHATE	6.25MG/5ML-10MG/5ML	120	ROSE, CAROLYN J MD
2/15/2016	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
3/11/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-7.5 MG	180	ROSE, CAROLYN J MD
4/18/2016	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
5/18/2016	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
6/10/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-7.5 MG	180	ROSE, CAROLYN J MD
6/17/2016	CARISOPRODOL	350 MG	90	ROSE, CAROLYN J MD
9/9/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-7.5 MG	180	ROSE, CAROLYN J MD
12/9/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-10 MG	180	ROSE, CAROLYN J MD

63. According to the CURES report for Patient F, during the period of on or about January 1, 2017, through on or about December 31, 2017, Patient F filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
1/24/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-7.5 MG	20	E.H. MD
3/10/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-10 MG	180	R.R. MD
6/9/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-10 MG	180	R.R. MD

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
8/18/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-10 MG	120	ROSE, CAROLYN J MD
11/8/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-10 MG	120	S.R. (NP)

64. According to the CURES report for Patient F, during the period of on or about January 1, 2018, through on or about May 22, 2018, Patient F filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
2/13/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-10 MG	120	ROSE, CAROLYN J MD
5/22/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325 MG-10 MG	90	ROSE, CAROLYN J MD

65. Respondent did not order an MRI, X-ray, referral to physical therapy or a pain management consultation for Patient F. Respondent diagnosed Patient F with degenerative disc disease absent any imaging studies or test in support of the diagnosis. Respondent did not test Patient E's reflexes, observe and document her gait, or perform and document a neurological examination related to her complaint of chronic back pain. Respondent did not attempt to confirm or investigate the diagnosis of degenerative disc disease by coordinating care with Patient F's other physicians. Respondent prescribed Patient F long-term narcotics without any attempt to consider less dangerous treatment options prior to prescribing controlled substances.

66. Respondent committed gross negligence in the care and treatment of Patient F, which included, but was not limited to the following:

A. Paragraphs 59 through 65, are hereby incorporated by reference as if fully set forth herein; and

B. Respondent failed to adequately diagnose and treat Patient F's lumbar disc disease.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

67. Respondent has subjected her Physician's and Surgeon's License No. A 41263 to disciplinary action under section 2227, as defined by section 2234, subdivision (c), of the Code, in that she committed repeated negligent acts in the care and treatment of Patient A, Patient B, Patient C, Patient D, Patient E, and Patient F, as more particularly alleged hereafter:

PATIENT A

68. Respondent did not provide Patient A with informed consent regarding the risks of taking benzodiazepines prior to prescribing benzodiazepines. Respondent did not provide Patient A with informed consent regarding the risk of taking benzodiazepines in combination with high-dose opiates. Respondent did not attempt to treat Patient A's insomnia with improved sleep hygiene, cognitive therapy, dietary changes, exercise, or through prescribing less dangerous medications. Respondent did not document an adequate justification for prescribing temazepam to Patient A for her insomnia.

69. Respondent did not document an adequate patient history relating to the presenting complaint at each visit. Respondent did not maintain an accurate and current medication list for Patient A. Respondent repeated phrases and large sections of documentation in patient examinations verbatim in each visit for Patient A. Respondent did not document any information in the medical records relating to Patient A's mentation or affect. Respondent did not document an adequate physical examination to support the plan for the patient or the prescribed medications.

70. Respondent did not document an examination of Patient A's thyroid. Respondent did not document any discussion with Patient A regarding her thyroid history and/or thyroid symptoms. Respondent prescribed Patient A hypothyroid medications absent any evidence of a corresponding thyroid examination. Respondent failed to order blood tests to adequately monitor Patient A's thyroid levels. Respondent failed to appropriately treat Patient A's hypothyroidism.

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71. Respondent did not provide any screening measures including influenza vaccinations, lipid screening, cervical cancer screening, colon cancer screening, Hepatitis C screening, osteoporosis screening or obesity counseling to Patient A.

72. Respondent committed repeated negligent acts in the care and treatment of Patient A, which included, but was not limited to the following:

A. Paragraphs 9 through 25 and 68 through 71, are hereby incorporated by reference as if fully set forth herein;

B. Respondent failed to provide Patient A informed consent regarding the risk of taking benzodiazepines in combination with high-dose opiates;

C. Respondent failed to maintain adequate and accurate medical records in connection with the care and treatment of Patient A;

D. Respondent failed to appropriately monitor and treat Patient A's hypothyroidism; and

E. Respondent failed to provide Patient A with adequate preventative care as her primary care physician.

PATIENT B

73. Respondent did not offer Patient B safer alternatives to narcotics to mange her pain, refer her to physical therapy, or arrange for a surgical intervention. Respondent did not attempt to determine the source of her neck pain. Respondent did not refer her to specialists, review prior treatment records or order imaging studies. Respondent prescribed controlled substances to Patient B for her back pain even though she was unaware of the source of Patient B's pain. Respondent did not adequately utilize CURES reports or pain management agreements in the treatment of Patient B.[35] Respondent did not adequately utilize toxicology tests in the treatment of Patient B while prescribing controlled substances.

74. Respondent did not maintain adequate and accurate records relating to the treatment of Patient B. Respondent repeated phrases and copied large sections of documentation in patient

[35] Respondent's only pain management agreement with Patient B was only recently signed on August 2, 2017, and a discussion of the agreement was not documented in Patient B's records.

examinations verbatim in each visit for Patient B from prior visits. Respondent did not update the social history and medication lists to ensure that the information was accurate at each visit. The social history section of the medical records repeated verbatim for nearly four years without change. Respondent's notes indicated that the social history, family history, past medical history, allergies and surgery history had not been reviewed and/or updated since April 10, 2013. Respondent did not document an adequate physical examination to support the assessment or plan for the patient at the same visit. Respondent did not document any information about Patient B's mentation or affect.

75. Respondent did not attempt any less dangerous alternative treatments for Patient B's complaint of muscle spasms. Respondent prescribed up to 240 pills of Soma each month without first attempting to treat Patient B with physical therapy, heat, stretching, or other less dangerous modalities. Respondent failed to prescribe less dangerous medications for muscle spasms prior to prescribing Soma. Respondent failed to provide Patient B with informed consent about the potential dangers of taking Soma. Respondent failed to provide Patient B with informed consent about the dangers of taking Soma in combination with other medications, including the high-dose opiates she received from Respondent. Respondent did not adequately monitor Patient B's liver function while taking Soma. Respondent inappropriately prescribed Patient B Soma in combination with Patient B's prescriptions for benzodiazepines, opiates and her continuing use of alcohol.

76. Respondent did not provide Patient B with appropriate screening measures as her primary care provider. Respondent did not provide any influenza vaccinations, lipid screening, cervical cancer screening, colon cancer screening, or Hepatitis C screening for Patient B. Respondent provided a single tetanus vaccine in 2016. Respondent failed to order a Tdap[36] for Patient B.

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[36] Tdap is a combination vaccine for tetanus, diphtheria and pertussis.

77. Respondent committed repeated negligent acts in the care and treatment of Patient B, which included, but was not limited to the following:

A. Paragraphs 27 through 34 and 73 through 76, are hereby incorporated by reference as if fully set forth herein;

B. Respondent failed to perform an appropriate evaluation of Patient B's neck pain and failed to offer safer alternatives for the treatment of her neck pain;

C. Respondent failed to maintain adequate and accurate medical records in connection with the care and treatment of Patient B;

D. Respondent inappropriately prescribed Soma to Patient B; and

E. Respondent did not provide adequate preventative medicine and screening examinations to Patient B.

PATIENT C

78. Respondent prescribed Patient C high-dose opiates in excess of 300 MME/day. Respondent ignored the red flags for opiate abuse and/or diversion. Patient C reported that her medications were not working, requested higher doses and refused to decrease her use of opiate medications. Respondent described Patient C as being hysterical, yet failed to document any information about Patient C's affect or mental status other than to note that she suffered from anxiety. Respondent required toxicology tests, but failed to follow up with Patient C regarding the results. Respondent failed to take any action after learning that Patient C was not taking the benzodiazepines prescribed. Respondent ignored a key red flag for potential diversion of medication by failing to take any action in response to Patient C's toxicology results that indicated she was no longer taking the prescribed benzodiazepines.

79. Respondent did not obtain medical records from Patient C's other medical providers. Respondent was aware that Patient C was receiving treatment for serious gastrointestinal problems from another physician at the same time that Respondent was treating her, but failed to document any communication or attempt to coordinate care with Patient C's gastroenterologist. Respondent's failure to coordinate care resulted in a duplication of therapy and prescriptions provided to Patient C. Respondent continued to prescribe Patient C NSAID's, despite the known

contraindication for patients with ulcer disease. Respondent did not attempt to notify Patient C's gastroenterologist or other providers about the care that she was providing. Respondent failed to review Patient C's CURES report to prevent duplication of therapy. Respondent treated Patient C for several years for degenerative disc disease without ever reviewing any objective evidence. Respondent's only basis for the diagnosis of degenerative disc disease was Patient C's self-reporting.

80. Respondent committed repeated negligent acts in the care and treatment of Patient C, which included, but was not limited to the following:

A. Paragraphs 36 through 44 and 78 through 79, are hereby incorporated by reference as if fully set forth herein;

B. Respondent failed to screen Patient C for opiate abuse disorder; and

C. Respondent failed to adequately coordinate care with Patient C's other medical providers.

PATIENT D

81. On or about October 7, 2015, Respondent had an appointment with Patient D, a then 58-year-old male. Patient D presented with a prior history that included diabetes, hypothyroidism, hyperlipidemia, emphysema, venous insufficiency, diabetic neuropathy, and schizophrenia. Patient D reported a history of smoking and denied alcohol use. In addition to being treated by Respondent, Patient D saw a psychiatrist who prescribed benzodiazepines. Respondent prescribed tramadol to Patient D for diabetic neuropathy. Respondent did not document any neurological evaluation or nerve studies for Patient D.

82. According to the CURES report for Patient D, during the period of on or about June 29, 2015, through on or about December 31, 2015, Patient D filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
6/29/2015	CLONAZEPAM	1 MG	60	D.B. MD
6/29/2015	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
7/27/2015	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
7/31/2015	CLONAZEPAM	1 MG	60	D.B. MD

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
9/19/2015	CLONAZEPAM	1 MG	60	D.B. MD
10/12/2015	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
10/25/2015	CLONAZEPAM	1 MG	60	D.B. MD
11/23/2015	CLONAZEPAM	1 MG	60	D.B. MD
12/8/2015	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
12/11/2015	CLONAZEPAM	1 MG	90	D.B. MD

83. According to the CURES report for Patient D, during the period of on or about January 1, 2016, through on or about December 31, 2016, Patient D filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
1/5/2016	CLONAZEPAM	1 MG	120	D.B. MD
2/8/2016	CLONAZEPAM	1 MG	120	D.B. MD
2/24/2016	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
3/7/2016	CLONAZEPAM	1 MG	120	D.B. MD
3/24/2016	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
4/19/2016	CLONAZEPAM	1 MG	120	D.B. MD
4/27/2016	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
5/17/2016	CLONAZEPAM	1 MG	120	D.B. MD
5/29/2016	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
6/16/2016	CLONAZEPAM	1 MG	120	D.B. MD
6/29/2016	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
7/22/2016	CLONAZEPAM	2 MG	60	D.B. MD
7/28/2016	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
8/17/2016	CLONAZEPAM	2 MG	60	D.B. MD
8/28/2016	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
9/17/2016	CLONAZEPAM	2 MG	60	D.B. MD
9/30/2016	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
10/18/2016	CLONAZEPAM	2 MG	60	D.B. MD
10/30/2016	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
11/25/2016	CLONAZEPAM	2 MG	60	D.B. MD
11/28/2016	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
12/26/2016	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
12/26/2016	CLONAZEPAM	2 MG	60	D.B. MD

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84. On or about September 1, 2017, Respondent added a diagnosis of schizophrenia for Patient D. According to the CURES report for Patient D, during the period of on or about January 1, 2017, through on or about December 31, 2017, Patient D filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
1/27/2017	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
2/13/2017	CLONAZEPAM	2 MG	60	D.B. MD
2/27/2017	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
3/16/2017	CLONAZEPAM	2 MG	60	D.B. MD
3/25/2017	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
4/19/2017	CLONAZEPAM	2 MG	60	D.B. MD
4/24/2017	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
5/18/2017	CLONAZEPAM	2 MG	60	K.S. (M.D.)
5/24/2017	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
6/20/2017	CLONAZEPAM	2 MG	60	D.B. MD
6/21/2017	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
7/23/2017	CLONAZEPAM	2 MG	60	D.B. MD
8/7/2017	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
8/26/2017	CLONAZEPAM	2 MG	60	D.B. MD
9/27/2017	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
9/27/2017	CLONAZEPAM	2 MG	60	ROSE, CAROLYN J MD
10/28/2017	CLONAZEPAM	2 MG	60	ROSE, CAROLYN J MD
10/28/2017	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
11/29/2017	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
11/29/2017	CLONAZEPAM	2 MG	60	ROSE, CAROLYN J MD
12/29/2017	CLONAZEPAM	2 MG	60	ROSE, CAROLYN J MD

85. According to the CURES report for Patient D, during the period of on or about January 1, 2018, through on or about May 21, 2018, Patient D filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
1/29/2018	TRAMADOL HCL	50 MG	120	ROSE, CAROLYN J MD
2/1/2018	CLONAZEPAM	2 MG	60	ROSE, CAROLYN J MD
3/2/2018	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
3/8/2018	CLONAZEPAM	2 MG	60	S.C.
3/25/2018	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
4/13/2018	CLONAZEPAM	2 MG	60	ROSE, CAROLYN J MD
4/18/2018	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD

Date Filled	Drug Name	Drug Strength	Qty	Prescriber Name
5/8/2018	TRAMADOL HCL	50 MG	90	ROSE, CAROLYN J MD
5/21/2018	CLONAZEPAM	1 MG	60	S.C.

86. Respondent did not utilize a pain management agreement or toxicology screenings in the treatment of Patient D. Respondent did not provide Patient D with informed consent regarding the possible risks of taking tramadol for neuropathy. Respondent did not document any effort to utilize less dangerous treatment options for Patient D's neuropathy prior to prescribing controlled substances. Respondent did not document any attempts to confirm the diagnosis of neuropathy during the care and treatment of Patient D. Respondent did not attempt to consult with or coordinate care with Patient D's psychiatrist regarding his medications and treatment.

87. Respondent was aware that Patient D had schizophrenia, but failed to include it in his medical records until 2017. Respondent said that "it's not in the chart uh, and that was one of my errors. You don't always think about putting it down when you're not doing it..." Respondent claims that it was not included in the chart "[b]ecause I don't treat him for it." Respondent failed to maintain an adequate and accurate list of Patient D's diagnoses in the medical records.

88. Respondent committed repeated negligent acts in the care and treatment of Patient D, which included, but was not limited to the following:

A. Paragraphs 81 through 87, are hereby incorporated by reference as if fully set forth herein;

B. Respondent inappropriately prescribed tramadol to Patient D for neuropathy; and

C. Respondent failed to maintain adequate and accurate medical records in connection with the care and treatment of Patient D.

PATIENT E

89. Respondent routinely prescribed Patient E approximately 120 pills per month of Soma for muscle spasms. Respondent did not discuss or attempt any less dangerous treatments for Patient E's muscle spasms including physical therapy, heat, stretching or other modalities. Respondent did not attempt to prescribe any less dangerous medications prior to prescribing

Soma. Respondent did not adequately consider the patient's family history of substance abuse prior to prescribing Soma to Patient E. Respondent prescribed Soma to Patient E in combination with opiates, even though it is recommended that Soma not be used for more than three weeks. Respondent did not document Patient E's muscle spasms in the physical examination.

90. Respondent did not provide and/or document any preventative care for Patient E including Pap smears, influenza vaccinations, lipid screening, cervical cancer screening, colon cancer screening, or Hepatitis C screening. Respondent did not perform CT scans on Patient E to screen for lung cancer.

91. Respondent did not document any communication or coordination of care with Patient E's treating psychiatrist. Respondent was aware that Patient E was concurrently receiving treatment and medications from her psychiatrist, but made no efforts to coordinate care in order to prevent dangerous drug interactions and/or duplication of therapy. Respondent and Patient E's psychiatrist were prescribing SNRIs[37] to Patient E at the same time. Respondent failed to consult Patient E's psychiatrist prior to prescribing Chantix to Patient E for smoking cessation. Respondent did not review Patient E's CURES reports or pharmacy records to prevent poly-pharmacy or duplication of therapy.

92. Respondent committed repeated negligent acts in the care and treatment of Patient E, which included, but was not limited to the following:

A. Paragraphs 46 through 57 and 89 through 91, are hereby incorporated by reference as if fully set forth herein;

B. Respondent inappropriately prescribed Soma to Patient E;

C. Respondent failed to provide adequate preventative medicine and screening examinations to Patient E; and

D. Respondent failed to coordinate care in the treatment of Patient E.

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[37] Serotonin and norepinephrine reuptake inhibitors are a class of medications that are effective in treating depression. They are sometimes used to treat anxiety disorders and long-term pain.

PATIENT F

93. Respondent did not consider less dangerous treatment options prior to prescribing Patient F opiates for her chronic pain. Respondent failed to demonstrate caution in prescribing hydrocodone to Patient F. Respondent did not utilize CURES reports, toxicology screenings or pain management agreements in the care and treatment of Patient F. Respondent failed to discuss and/or document a discussion of the risks of consuming alcohol while taking opiates with Patient F. Respondent failed to adequately monitor Patient F while she was taking controlled substances.

94. Respondent committed repeated negligent acts in the care and treatment of Patient F, which included, but was not limited to the following:

A. Paragraphs 59 through 65 and 93, are hereby incorporated by reference as if fully set forth herein; and

B. Respondent inappropriately prescribed controlled substances to Patient F.

THIRD CAUSE FOR DISCIPLINE

(Excessive Prescribing)

95. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 725, subdivision (a), of the Code, in that she repeatedly prescribed clearly excessive amounts of controlled substances to Patient A, Patient B, Patient C, Patient D, Patient E, and Patient F, as more particularly alleged in paragraphs 9 through 25 and 68 through 71 (Patient A), 27 through 34 and 73 through 76 (Patient B); 36 through 44 and 78 through 79 (Patient C), 81 through 87 (Patient D), 46 through 57 and 89 through 91 (Patient E), and 59 through 65 and 93 (Patient F), which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Incompetence)

96. Respondent has subjected her Physician's and Surgeon's License No. A 41263 to disciplinary action under section 2227, as defined by section 2234, subdivision (d), of the Code, in that she committed incompetence in the care and treatment of Patient A, Patient B, Patient C, Patient D, and Patient E, as more particularly alleged hereafter:

PATIENT A

97. Respondent committed incompetence in the care and treatment of Patient A, which included, but was not limited to the following:

A. Paragraphs 9 through 25 and 68 through 71, are hereby incorporated by reference as if fully set forth herein;

B. Respondent's failure to adequately prescribe methadone and/or manage Patient A while prescribing methadone demonstrates a lack of knowledge and/or incompetence;

C. Respondent inappropriately prescribed controlled substances and/or managed Patient A while prescribing controlled substances, which demonstrates a lack of knowledge and/or incompetence;

D. Respondent failed to provide Patient A informed consent regarding the risk of taking benzodiazepines in combination with high-dose opiates, which demonstrates a lack of knowledge and/or incompetence;

E. Respondent failed to appropriately monitor and treat Patient A's hypothyroidism, which demonstrates a lack of knowledge and/or incompetence; and

F. Respondent failed to provide Patient A with adequate preventative care, which demonstrates a lack of knowledge and/or incompetence.

PATIENT B

98. Respondent committed incompetence in the care and treatment of Patient B, which included, but was not limited to the following:

A. Paragraphs 27 through 34 and 73 through 76, are hereby incorporated by reference as if fully set forth herein;

B. Respondent inappropriately prescribed benzodiazepines to Patient B, demonstrating a lack of knowledge and/or incompetence; and

C. Respondent inappropriately prescribed Soma to Patient B, demonstrating a lack of knowledge and/or incompetence.

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PATIENT C

99. Respondent committed incompetence in the care and treatment of Patient C, which included, but was not limited to the following:

A. Paragraphs 36 through 44 and 78 through 79, are hereby incorporated by reference as if fully set forth herein;

B. Respondent inappropriately prescribed NSAID's in a patient with known ulcer disease, demonstrating a lack of knowledge and/or incompetence; and

C. Respondent failed to screen Patient C for opiate abuse disorder, demonstrating a lack of knowledge and/or incompetence.

PATIENT D

100. Respondent committed incompetence in the care and treatment of Patient D, which included, but was not limited to the following:

A. Paragraphs 81 through 87, are hereby incorporated by reference as if fully set forth herein;

B. Respondent inappropriately prescribed tramadol to Patient D for neuropathy, demonstrating a lack of knowledge and/or incompetence; and

C. Respondent inappropriately prescribed NSAID medications to Patient D, demonstrating a lack of knowledge and/or incompetence.

PATIENT E

101. Respondent committed incompetence in the care and treatment of Patient E, which included, but was not limited to the following:

A. Paragraphs 46 through 57 and 89 through 91, are hereby incorporated by reference as if fully set forth herein;

B. Respondent inappropriately prescribed Soma to Patient E, demonstrating a lack of knowledge and/or incompetence; and

C. Respondent failed to provide adequate preventative medicine and screening examinations to Patient E, demonstrating a lack of knowledge and/or incompetence.

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FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

102. Respondent has subjected her Physician's and Surgeon's License No. A 41263 to disciplinary action under section 2227, as defined by section 2266, of the Code, in that she failed to maintain adequate and accurate records in connection with her care and treatment of Patient A, Patient B, and Patient D, as more particularly alleged in paragraphs 9 through 25 and 68 through 71 (Patient A), 27 through 34 and 73 through 76 (Patient B); 81 through 87 (Patient D), which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 41263, issued to Carolyn Joan Rose, M.D.;

2. Revoking, suspending or denying approval of Carolyn Joan Rose, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Carolyn Joan Rose, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: July 6, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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